January, 1955

Canadian Hospital

- *Patients and books*
- *I became a student again*
- *Recent findings in meat research*
- *A surveyor discusses accreditation*
- *The Minister reviews the health scene*

Canadian Hospital Association

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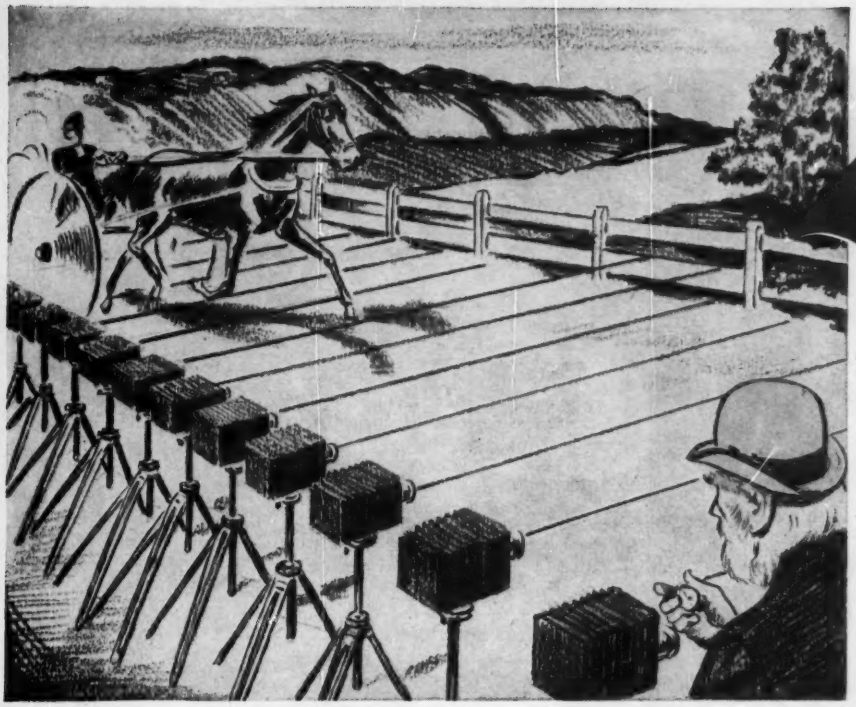

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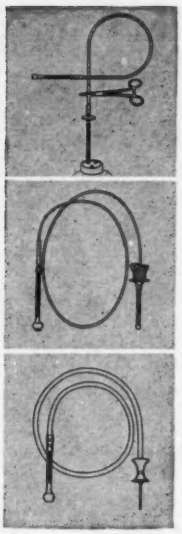

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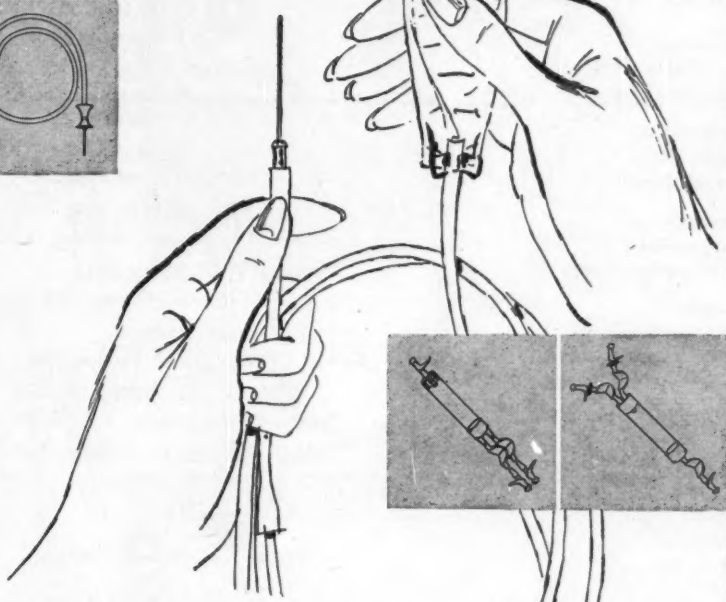

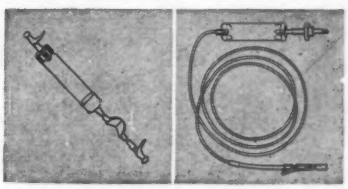

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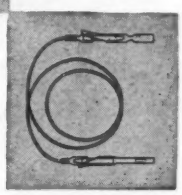

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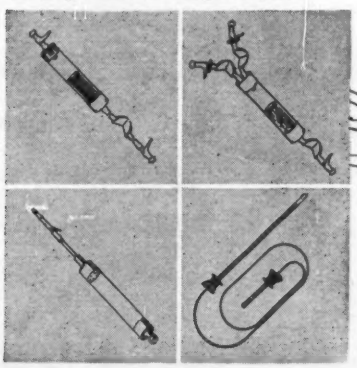

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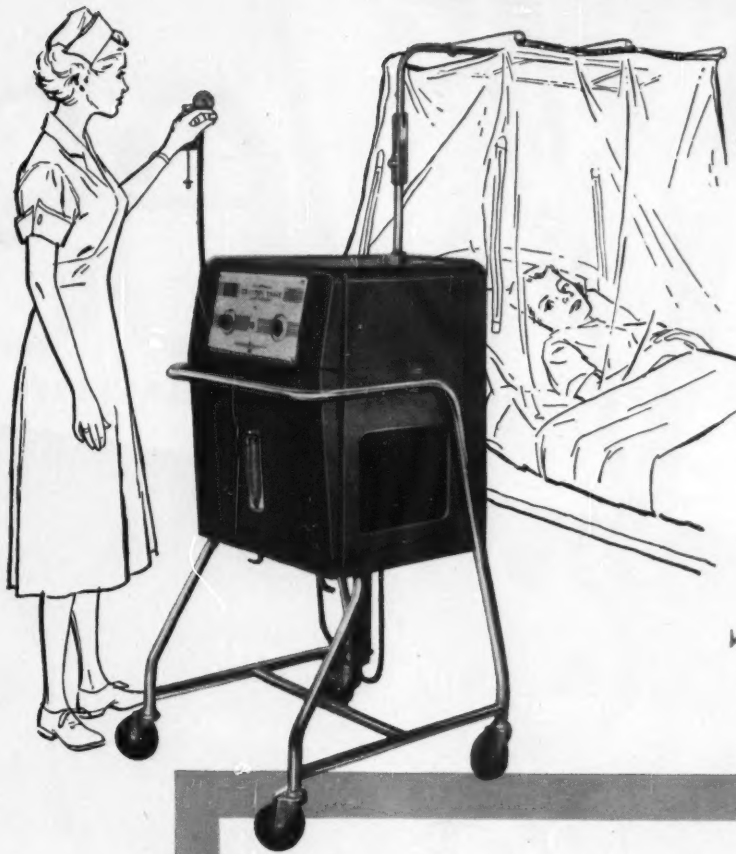

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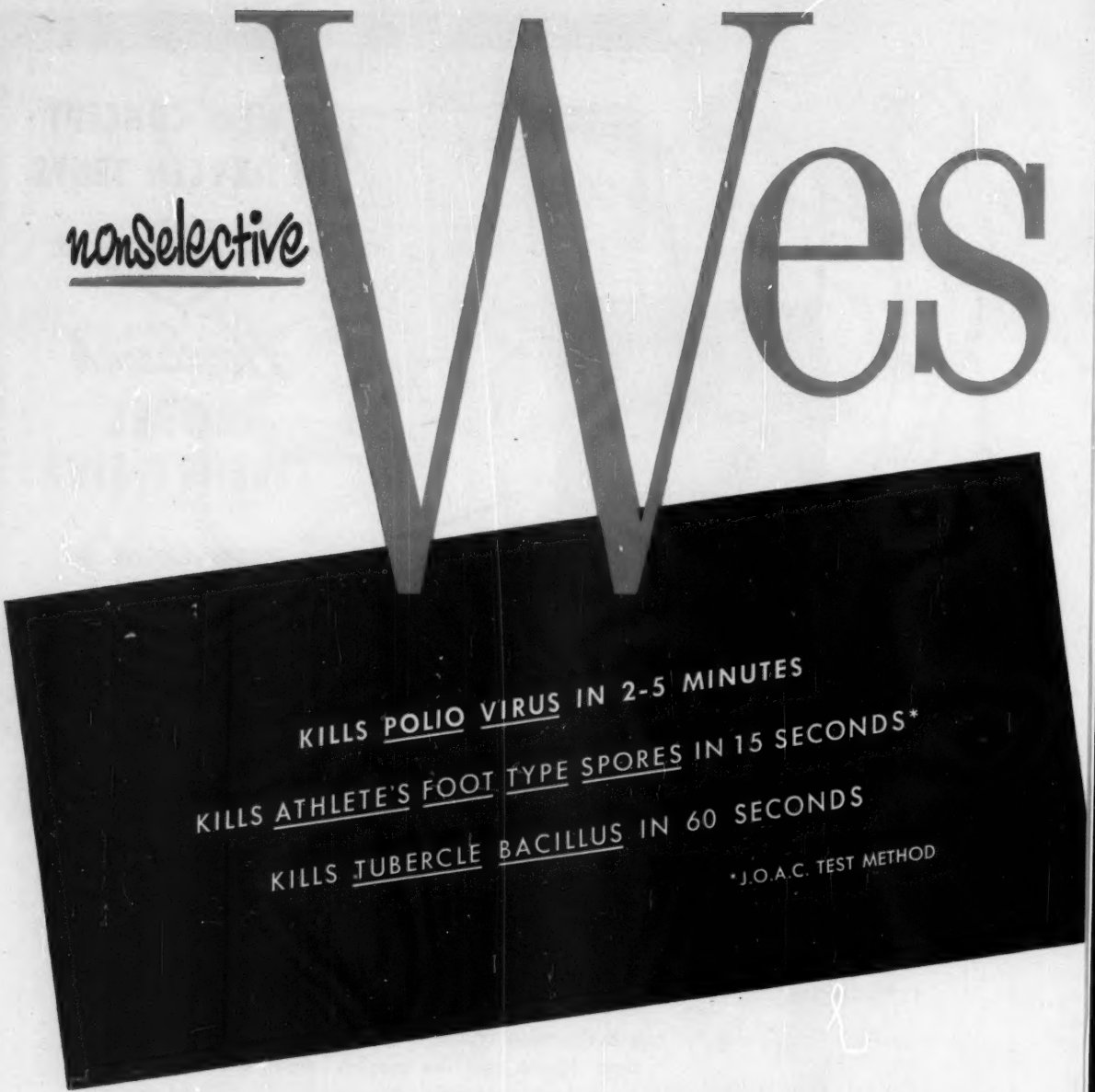

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More Effective Germicide In comparative tests with three common disinfectants, only WESCODYNE was able to kill and completely stop bacterial growth in ten successive contaminations by rings carrying the same organisms. The table below lists the number of positive tubes (those having bacterial growth or incomplete kill) found after each contamination.

Organism	Wescodyne 75 ppm iodine	Sodium Hypochlorite 100 ppm	Phenolic Type 1:100	Quaternary Compound, 200 ppm
S. choleraesuis	0	0	0	1
M. pyogenes var. aureus	0	4	2	1

The method used was developed by the USDA to confirm recommended use dilutions based on phenol coefficient studies.

In other tests, the capacity of WESCODYNE for germicidal action was found to be over three times that of use dilutions of sodium hypochlorite or quaternary.

Highly Virucidal WESCODYNE has been found to completely inactivate polio virus within two minutes. Under identical conditions, a widely used cresylic type disinfectant (at recommended use dilution) failed completely to inactivate the virus.

Against influenza and Newcastle disease viruses, investigators found WESCODYNE virucidal at dilutions as low as 1 ppm available iodine, in contrast to the suggested use concentration of 75 ppm. The results below demonstrate this potent action against influenza virus.

VIRUCIDAL ACTION VERSUS INFLUENZA VIRUS

Controls No. of Eggs	No. of Lethal Doses of Virus/Egg	Total Positive Eggs	Total Negative Eggs
5	10^5	5/5	0/5
5	10^3	5/5	0/5
5	10	5/5	0/5

Wescodyne Iodine conc. ppm	No. of Lethal Doses of Virus/Egg	Contact Time	Total Negative Eggs
25	10^5	2 min.	5/5
25	10^3	2 min.	5/5
25	10	2 min.	5/5
10	10^3	2 min.	5/5
5	10	2 min.	5/5
1	10	2 min.	5/5

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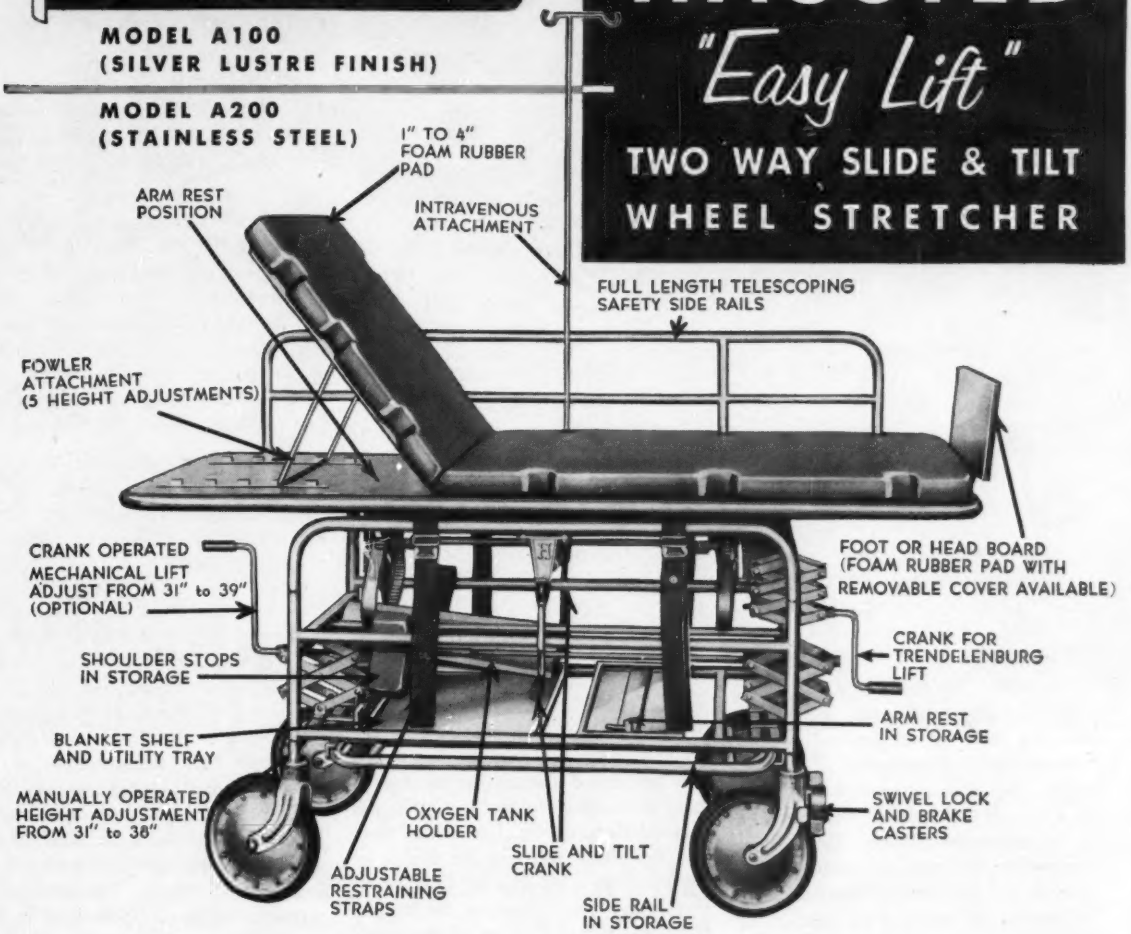

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◂ Notes About People ▸

Changes in Senior Appointments at Federal Health Department

Several top-level changes have been announced recently in the organization of the Health Branch of the Department of National Health and Welfare, Ottawa.

Dr. F. W. Jackson, formerly director of health insurance studies, has been appointed director of health services. A former deputy minister of health for Manitoba, Dr. Jackson was called to Ottawa in 1948 to direct the federal government's National Health Program. As director of health services, he will be responsible for the department's activities insofar as they relate to assistance to the provinces. Dr. Jackson will be assisted by Drs. K. C. Charron, B. D. B. Layton, G. E. Wride, and C. A. Roberts.

Dr. Wride was director of hospital planning and administration in the Saskatchewan department of health before he was appointed assistant director of the federal department's health insurance studies. He will be responsible for making recommendations to the director of health services in matters of policy with relation to the federal health grants and their administration.

Drs. J. H. Horowicz and J. B. Bundock will assist Dr. Wride. Dr. Horowicz, who becomes chief administrative officer of the health grants program came to the department in 1945 from the Department of National War Services. Dr. Bundock recently arrived from overseas where he had been serving with the Canadian Emigration Office at the Hague. Both men have had considerable legal training. Dr. Horowicz earned his doctor of law's degree at Grakor University, Poland, while Dr. Bundock has studied law at the Hague and also at Laval University.

In addition to present duties, as head of the deparment's mental health division, Dr. C. A. Roberts will now direct research in health insurance studies.

Dr. K. C. Charron will be responsible for the divisions of occupational health and public health engineering, as well as for several special projects now under his supervision. He is also the department's representative on the National Advisory Committee on the Rehabiliation of Disabled Persons.

Dr. B. D. B. Layton joined the department in 1945. He will provide general supervision for the department's research program.

The divisions of quarantine, immigration medical and sick mariners services, civil service health, and civil aviation medicine will now constitute a separate group under the supervision of Dr. R. G. Ratz as principal medical officer.

* * * *

Dr. Brian McPhillips Appointed to Staff at St. Catharines General

Dr. Brian McPhillips, formerly clinical assistant in radiology at the Royal Victoria Hospital, Montreal, has been appointed assistant in the department of radiology at the St. Catharines General Hospital, St. Catharines, Ont. Dr. McPhillips received the degree of licentiate of the Royal College of Physicians and Surgeons in Ireland from the Royal College of Surgeons, Dublin, in 1942. From July, 1946, to September, 1950, he was medical officer with UNRA in Germany, with the United States Army. He joined the staff of the Royal Victoria Hospital, Montreal, as a senior intern in July, 1951.

* * * *

Appointment at Royal Victoria

Dr. W. Clifford M. Scott, formerly of London, Eng., has been appointed psychiatrist in the department of psychiatry of the Royal Victoria Hospital, Montreal, and associate professor of psychiatry at McGill University, to organize psychoanalytic training. Before coming to Canada, Dr. Scott was director of the London Clinic of Psychoanalysis, teacher at the Institute of Psychiatry, and a member of the staff of the Bethlem Royal and Maudsley Hospital, London, Eng.

• Donald J. Avison has been appointed chairman of the board of the University of Alberta Hospital, Edmonton.

• R. J. Pinchin is the new president of the board of St. Andrew's Hospital, Midland, Ont.

• Chairman of the board of directors of the Dartmouth Memorial Hospital, Dartmouth, N.S., is A. C. Pettipas.

Changes in Location for Two National Organizations

The national headquarters of the Canadian Nurses' Association, formerly located in Montreal, are now in the nation's capital. The new address is: Canadian Nurses' Association, Excelsior Life Insurance Building, 270 Laurier Ave., West, Ottawa, Canada.

Moving from Ottawa, the Canadian Arthritis and Rheumatism Society now has its national office in Toronto. The new location is: Room 306, 600 Jarvis Street, Toronto, Ont.

Fewer Personnel in French Hospitals

In the *Report of the Study Tour of Hospitals in France*, published by the International Hospital Federation, it is noted that the number of staff in practically all departments of the French hospitals visited was very small. "Ward units of 30 beds were staffed by a sister and one nurse with the help of orderlies who do the cleaning, fetching, and carrying. The standard of nursing is high. Much of it is done by the sisters, who are generally members of religious orders. Although they work long hours, they are always cheerful and most devoted to their patients. Help is also given to the nursing staff by medical students who "walk the wards" from their first year. The employment of married nurses living outside the hospital is an interesting feature. Ward work is well organized—there is an air of efficiency, albeit also an atmosphere of peace. The relations between patients and staff and between the various sections of the staff themselves, are excellent. . . . Patients are well treated and have no complaints to make. In a number of hospitals visited, patients were singing, a fact which impressed many participants. Theatre staff seems to be about one-half of that generally observed in theatres in other countries. Kitchen staff is also small in numbers. The general impression seems to be that efficient organization lessens the number of staff required."

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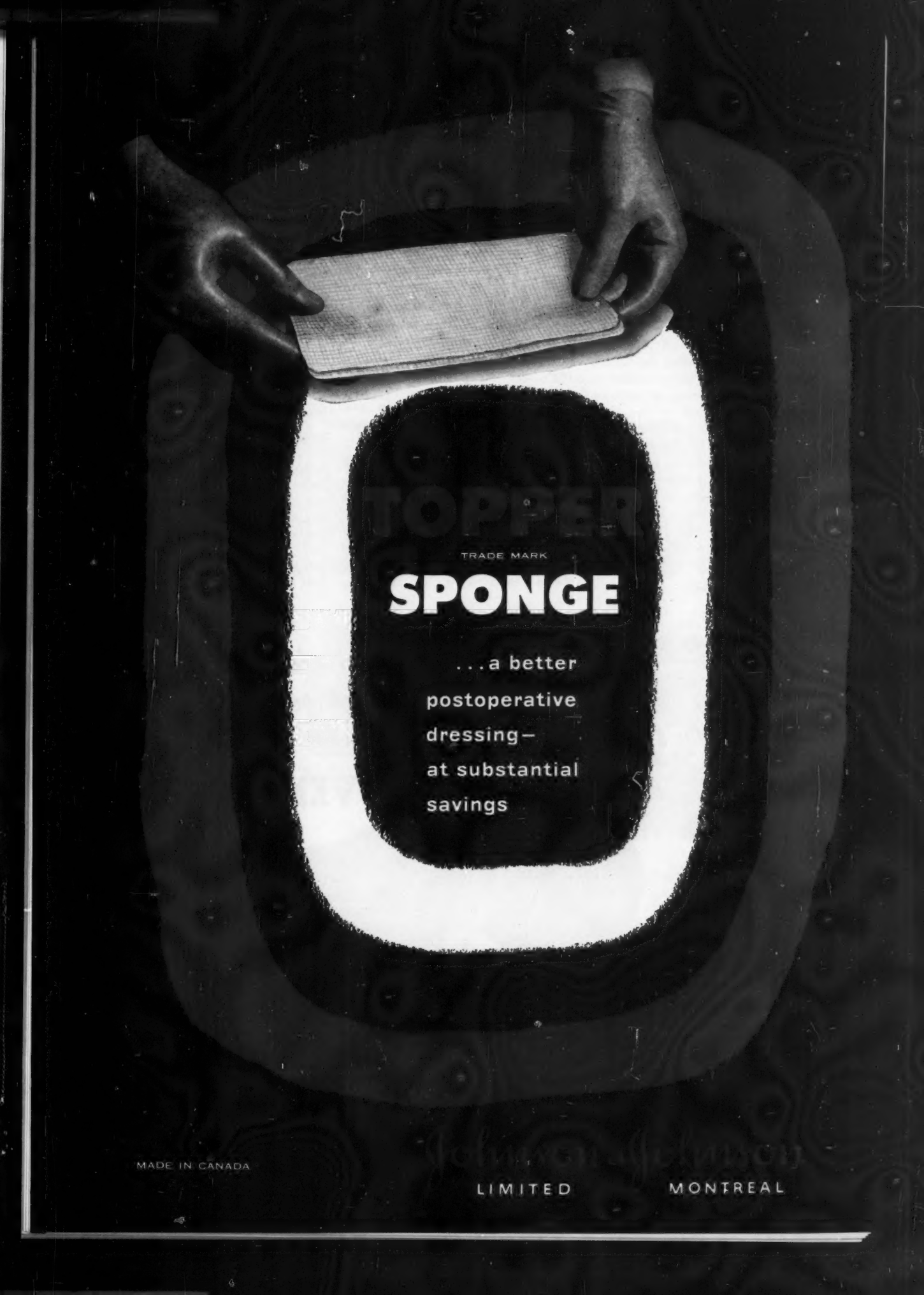
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Rehabilitation Centre in Korea

In a cluster of barracks buildings at Tongnae, Korea, on the outskirts of Pusan, a new chance for a useful life is being given to Korean amputees. There, at the Tongnae National Rehabilitation Centre, sponsored by the United Nations Korean Reconstruction Agency (UNKRA), a staff of Korean and international personnel is slowly helping victims of amputation and other physical disfigurement to overcome their handicaps.

Dr. James Petrie of Aberdeen, Scotland, project chief of the Centre, hopes that its work will contribute to a growing public sense of responsibility for handicapped persons. However, there are some basic difficulties. The first problem is the attitude of the patients themselves as many of the amputees consider themselves social outcasts. They are seldom seen on the street; but remain hidden in the bosom of their family group, which has a highly developed sense of responsibility toward its own indigent or unlucky members.

The American Korean Foundation, a voluntary agency, is co-sponsoring the rehabilitation project. The Foundation has made it possible, through funds and other aid, for the Korean staff to devote their entire time to the 300-bed centre, has assisted in obtaining medical personnel, and is considering expanded participation in further work on the building.

UNKRA spent $35,500 on equipment and about $83,000 on renovating the barracks buildings under its 1953 program. It has obligated $283,000 from 1954 funds, with expenditures of a further $170,000 planned. Some $190,000 has been spent on new equipment now arriving in or en route to Korea.

Amputees who come to the Centre already equipped with artificial limbs get them from the United States and Republic of Korea Army sources. The Centre's workshops turn out a small quantity of braces and limb parts and will soon manufacture complete prostheses. Included in the incoming equipment is enough seasoned willow for a year's supply of lightweight limbs of a type considered suited to Korean conditions, along with machinery for working the wood into the proper form. The Centre's adviser of job placement has already placed some 300 trained workmen through the employment offices of the United States and Commonwealth armed forces and Korean civilian agencies. However, the Centre can only hope to care for a small fraction of the estimated 15,000 amputees in the Republic. — *UN Department of Public Information.*

Montreal Kinsmen Aid Hospitals

St. Justine's Hospital, Montreal, will be granted $71,300 and the Children's Memorial Hospital, Montreal, $43,200 to operate their cerebral palsy rehabilitation program. The announcement was made at a combined meeting of the Kinsmen Trust Fund Committee, and the Cerebral Palsy Association of Quebec, Inc. The money is part of $220,000 raised by the Kinsmen "Telethon" held last March.

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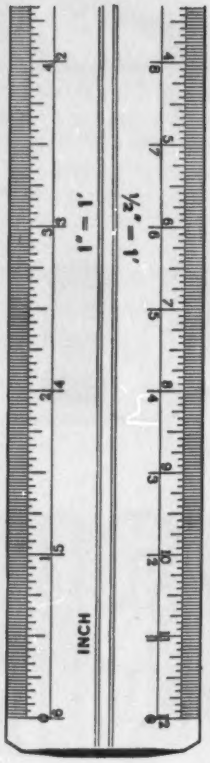

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Riboflavin (vitamin B_2)	1 mg.	Vitamin C (ascorbic acid)	50 mg.

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Vitamin A	10,000 Int. units	Vitamin B_{12} (crystalline)	3 mcg.
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Riboflavin (vitamin B_2)	3 mg.	Vitamin C (ascorbic acid)	75 mg.
Vitamin B_6 (pyridoxine hydrochloride)	1.5 mg.		

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Whatever its name—Protein Malnutrition is Widespread

Need for a concerted attack by the farmer, food processor, medical research specialist and health education leader against "protein malnutrition" in young children is indicated in a Food and Agriculture Organization report. This problem is one of fundamental importance in many areas and is known by some 40 different names.

In some parts of Africa, FAO stated, the incidence of protein malnutrition is so high that every child at some time of his life is reported to suffer from it. The deficiency is often so severe that the mortality rate among cases admitted to hospitals was until recently as high as 50 per cent. The condition can be prevented, usually, by giving a child plenty of milk but the problem, the report makes clear, is to provide such a diet in parts of the world where milk is scarce and protein-rich substitutes are not in common use. To meet this problem, the report proposes measures such as better use of locally available protein sources (fish or soybeans) and changing dietary habits by public education, through village societies and youth clubs.

In recent years, there has been a flood of reports from all over the world of the same disease taking its toll of children—but under a host of different names which by their variety had previously obscured the wide occurrence of the condition.

In South Africa, it has been called "infantile pellagra" and in Jamaica, "fatty liver disease" or "sugar baby". The French once called it "dystrophie des farineux", and the Germans, "Mehlnarhrschaden". In the Belgian Congo, it is sometimes called "M'Buaki", in India, "nutrition dystrophy" or "nutritional oedema syndrome" and in Latin America, "distrofia pluricarencial infantil".

The report of the joint FAO and WHO expert committee on nutrition lists nearly 40 different names used to cover what is in general the same condition. But, whatever the name, the signs and symptoms are similar and the same curative treatment usually brings the same results.

The most effective treatment in the majority of cases simply consists of putting the child on a diet of protein-rich skim milk. In the most serious cases, blood transfusions may be necessary at first. In the majority of cases, dietary treatment will restore gravely ill children to health in a matter of weeks. In some African hospitals, it has reduced the death rate from the disease from over 50 per cent to almost the vanishing point.

While much further detailed research on many aspects of protein malnutrition is needed, the basic facts are simple. Infants and young people, like all young animals, need a diet rich in protein for growth. The infant obtains the protein it needs from its mother's milk as long as its mother can provide enough milk. However, as the child grows larger, its diet must be supplemented from outside sources. In many countries, there is no milk for children other than their mother's milk. FAO has widely investigated means of raising milk production in many parts of the world. The United Nations Children's Fund has financed milk processing plants in several areas.

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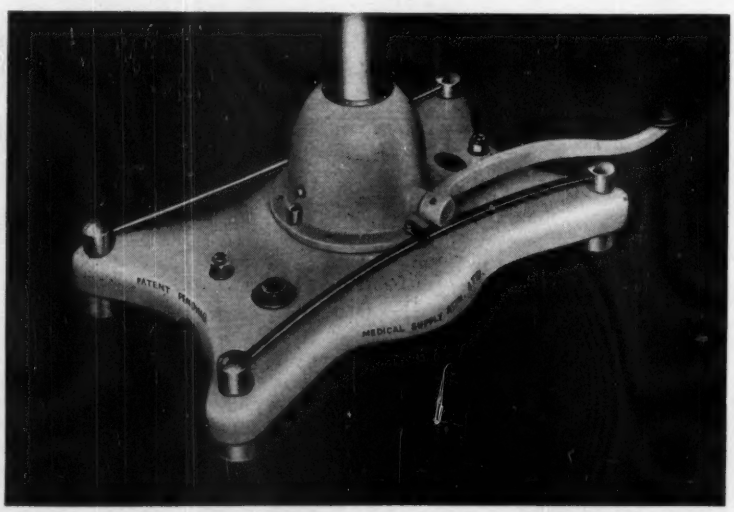

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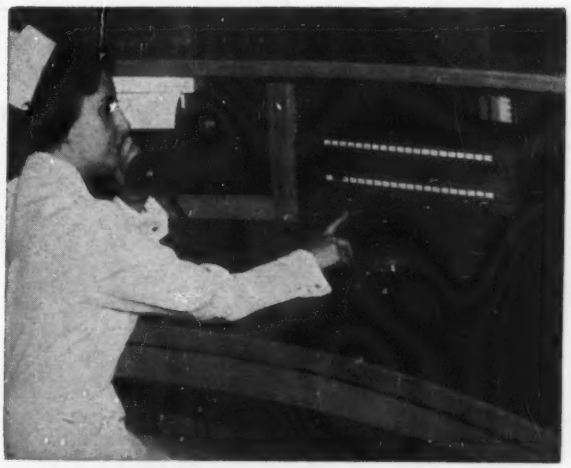

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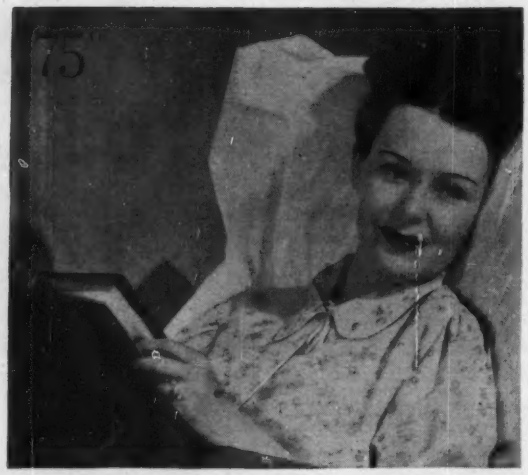

In room 204, this patient is well on her way to recovery from minor surgery. Her doctor felt that a temperature of 75° would contribute most to her sense of well-being. This is easily possible because of the Honeywell Hospital Thermostat installed right in her room.

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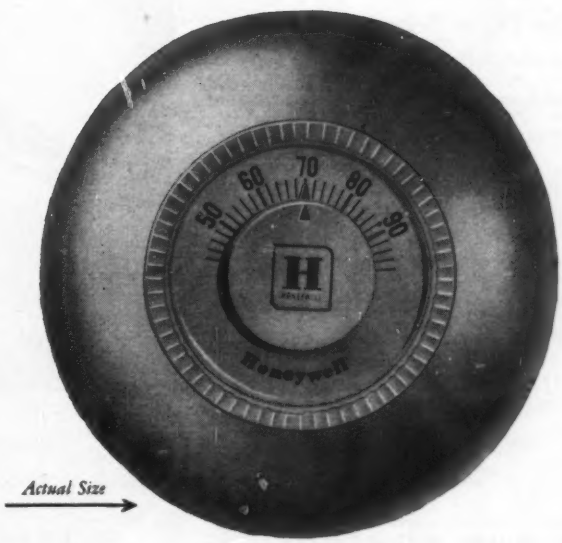

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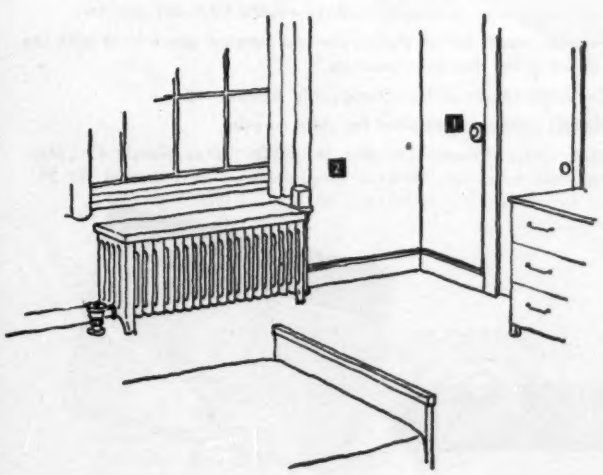

The sketch at left shows how easily the Honeywell Round System can be installed in individual rooms in *your* hospital. The attractive thermostat (**1**) blends with the wall . . . it's connected to a Honeywell automatic radiator valve (**2**) and a small transformer by a tiny wire. It's just as simple and economical as it sounds!

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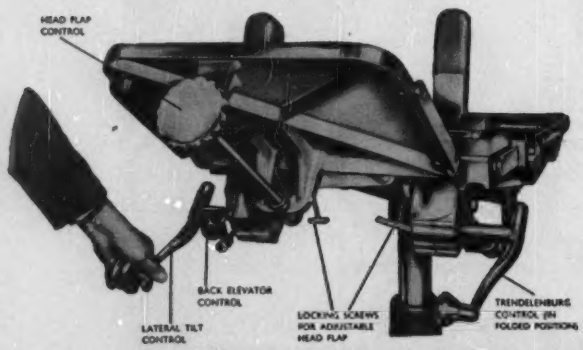

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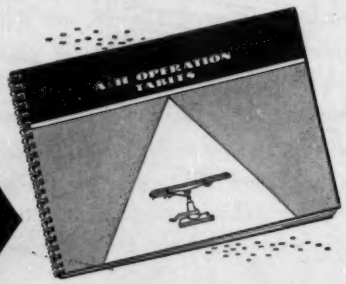

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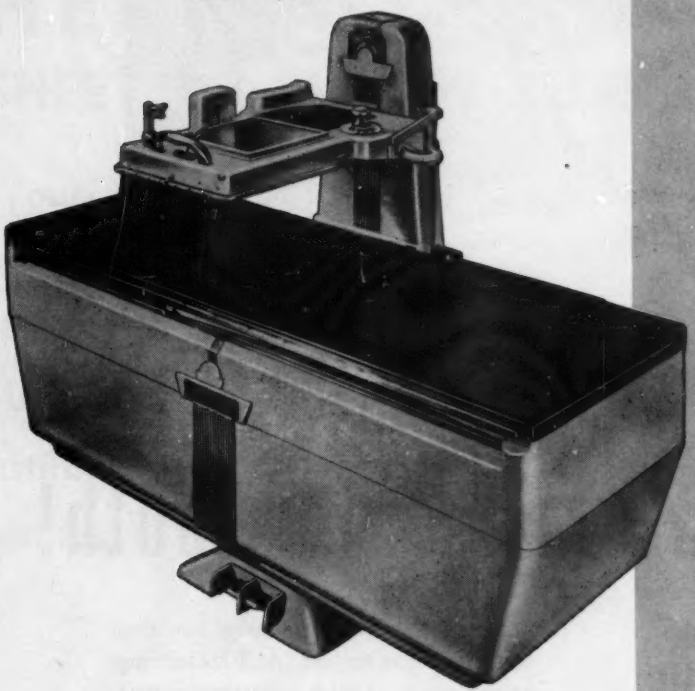

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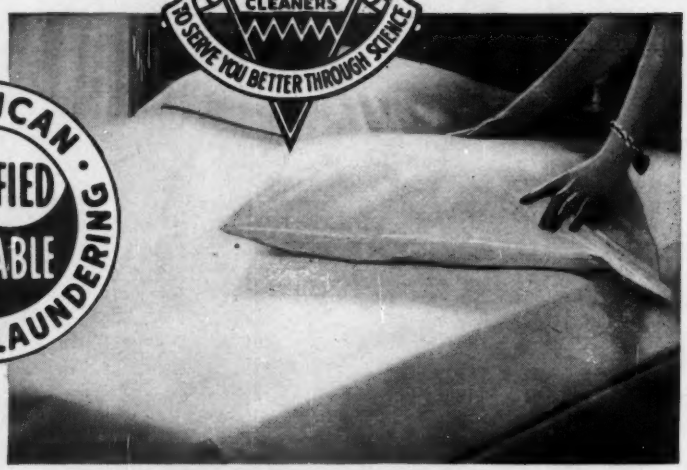

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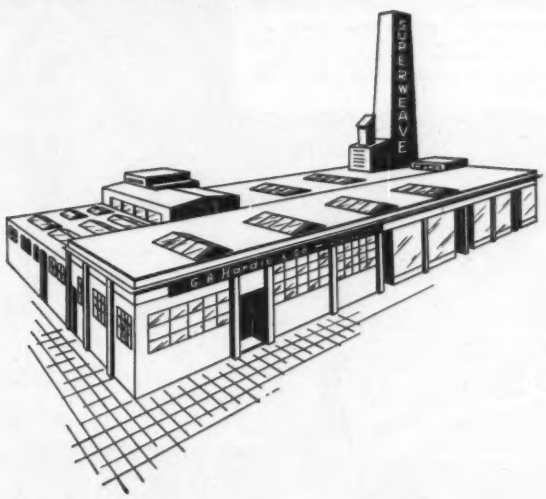

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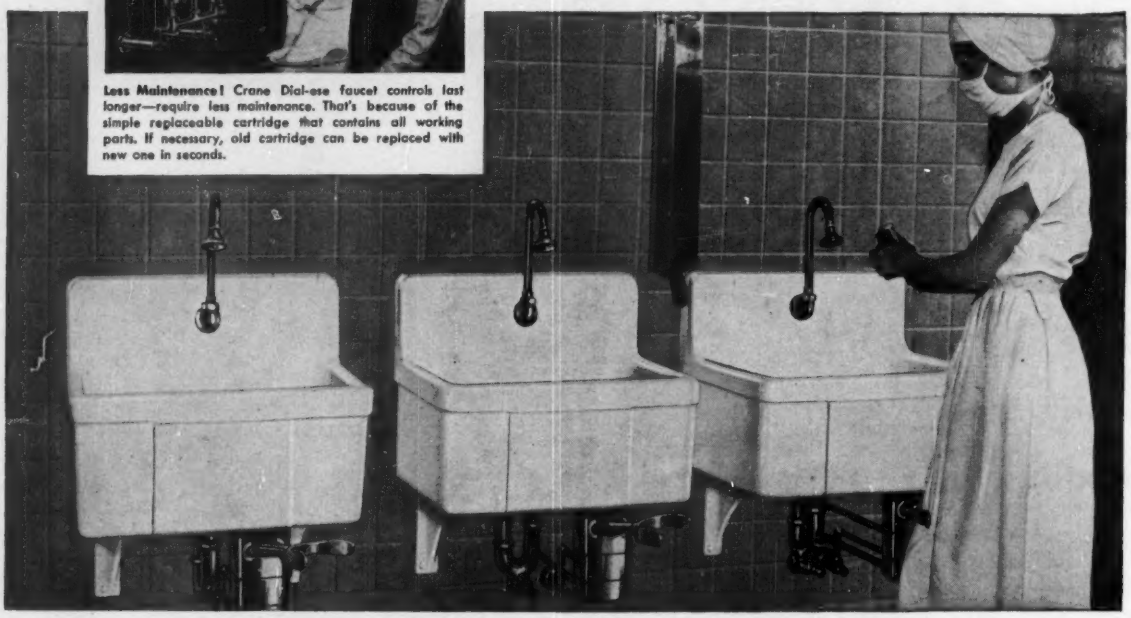

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The Canadian Hospital

Obiter Dicta

Canadian Commission in Action

AT THE ANNUAL meeting of the Canadian Commission on Hospital Accreditation, which was held in Toronto on December 9th, satisfactory progress in surveying Canadian hospitals was reported. Two surveyors, Dr. Karl Hollis and Dr. Jean J. Laurier, have been busily engaged in field work since April 1954.

The Canadian Commission on Hospital Accreditation numbers 12 commissioners representing four national organizations: the Canadian Medical Association, which has four seats; L'Association des Médecins de langue française du Canada, one; the Royal College of Physicians and Surgeons of Canada, two; and the Canadian Hospital Association, five. With respect to the latter, it will be remembered that at the 1953 biennial meeting in Ottawa, the Canadian Hospital Association designated one of these five seats to a representative of the Catholic Hospital Association of Canada.

Reports from the two field surveyors employed by the Canadian Commission show that, during 1954, they visited a total of 98 Canadian hospitals. In addition, field surveyors of the American Hospital Association, the American College of Surgeons, and the American Psychiatric Association, visited an additional 57 Canadian hospitals for a total of 155. This compares with 90 Canadian hospitals surveyed during 1953. Of the 155 hospitals surveyed during 1954, 20 had a capacity of 25 to 50 beds; 21 a capacity of 50 to 100 beds; 34 a capacity of 101 to 150 beds; 21 were in the range of 151 to 200 beds; and 59 hospitals which were surveyed had 200 or more beds. Of the 155 hospitals visited, 94 were fully approved; 36 provisionally approved; 12 were not approved; and 13 were visited but not rated. Thirteen of the hospitals were in British Columbia; 4 in Alberta; 11 in Saskatchewan; 5 in Manitoba; 13 in Ontario; 51 in Quebec; 14 in New Brunswick; 29 in Nova Scotia; 6 in Prince Edward Island, and 9 in Newfoundland.

When it is considered that the field survey work of Dr. Hollis and Dr. Laurier commenced only in April, 1954, the Canadian Commission on Hospital Accreditation is to be congratulated on the work accomplished last year. Up to date, all Canadian hospitals which have requested surveys have been inspected except two. On the other hand, when it is remembered that less than 40 per cent of hospitals in Canada with a capacity of over 25 beds have ever been surveyed, it is apparent that much remains to be done and it is expected that more and more Canadian hospitals will apply for surveys this year.

Following the last biennial meeting of the Canadian Hospital Association, member associations agreed to increase, substantially, their financial contributions to their national organization, in order to support the work of the Canadian Commission on Hospital Accreditation. It should be emphasized again that, apart from the contribution which the individual hospital makes to its provincial association there is no fee charged to any hospital for a survey. It is to be remembered, also, that accreditation is a voluntary matter and that to have a survey a hospital must make a request, addressed to the Joint Commission on Accreditation of Hospitals, 660 North Rush Street, Chicago, Ill. Neither representatives of the Joint Commission nor either of the two field surveyors of the Canadian Commission will survey a hospital until this formal application has been made.

If your hospital has not had an accreditation survey, your administrator should discuss the matter with the board of governors and the medical staff. Factual infor-

mation on the requirements for accreditation is published by the Joint Commission on Accreditation and is available to all. In this issue, *The Canadian Hospital* is pleased to publish an article by Dr. Karl Hollis which provides much helpful information on accreditation (See page 33).

The object of the program of accreditation is to encourage physicians and hospitals to apply voluntarily certain basic principles of organization and administration in order to achieve higher standards of patient care, through co-ordinated efforts on the part of the organized medical staff and the governing board. The Canadian Commission on Hospital Accreditation stands ready to assist Canadian hospitals to attain this end.

What do the C.H.A. extension courses offer?

ON PAGE 74 of this issue is published the formal announcement regarding the Canadian Hospital Association's extension courses for 1955. The next classes in hospital organization and management and for medical record librarians commence in September, 1955.

Today, adequate preparation and training are essential for those entering key administrative positions in the hospital. While in the past many outstanding leaders in all walks of life have made great contributions with a minimum of formal education, it is undoubtedly true that they would have made an even greater contribution had they had the opportunity of formal education. No one will minimize the essential part that experience plays in a vocation; but in these days of specialization some formal education is of basic importance. This is especially true as it applies to hospital administration. Since the end of World War II, there has been a great expansion in the Canadian hospital field. Many new hospitals have been built, new people have come into the field and others have been promoted within the hospitals themselves.

The purpose of the extension course in hospital organization and management, offered by the Canadian Hospital Association, is to assist the person who is already in a senior position in a hospital and who is unable to enrol in existing university programs. It is designed to cover a period of two years to allow such people to increase their knowledge of hospital administration while they carry on with their day-to-day work. It consists of two winter sessions conducted on a home study basis, with summer classroom sessions of four weeks duration each year, held at a Canadian university. Curriculum content is supervised by the faculty of the Department of Hospital Administration of the University of Toronto; and leading hospital administrators have assisted in the preparation of lesson material. Faculty for the summer sessions are authorities in hospital and health fields. Thus the course is the result of a co-operative effort with many organizations and individuals actively participating to make it possible.

The founders of the extension course in hospital organization and management were very wise when they stipulated that an essential feature of the course was the summer sessions. Many phases of hospital administration can be profitably explored through the media of the home study course but the summer sessions are vital in that it is here that the whole class comes together as a group, in a university atmosphere, for intensive review of the curriculum, to receive inspiration, and to learn from each other. On page 45 we are pleased to publish an article by a former student who took the course in hospital organization and management, setting out in his own words the benefits which he considers he derived from his course of study.

The extension course for the training of medical record librarians, is sponsored by the Canadian Hospital Association in co-operation with the Canadian Association of Medical Record Librarians. The basic plan of the course is similar to that of the course in hospital organization and management, with the intra-mural summer session being held in a hospital. This course provides an opportunity for those unable to take the regular twelve months course for medical record librarians, as given in existing hospital schools. Those who can should be encouraged to take the regular twelve months course. For those who for various reasons cannot, the extension course will be of value in increasing their usefulness to the medical records department.

The Canadian Hospital Association's two extension courses are undoubtedly meeting a need in the Canadian hospital field. While September, 1955, may appear a long way off, those seriously contemplating enrolling should do so now as it takes several months for the Association to finalize all necessary details.

Time Analysis of Head Nurse Activity

RECENTLY, THE HONOURABLE Paul Martin, Minister of National Health and Welfare, released a report entitled "*A Study of the Functions and Activities of Head Nurses in a General Hospital* (see page 43). This study was conducted by the Research Division, Department of National Health and Welfare, at the request of the Canadian Nurses' Association. The study was made with the co-operation of the Ottawa Civic Hospital.

The responsibility for planning and directing the project was assigned to Gordon A. Josie, supervisor of the Methods and Analysis Section, by M. J. W. Willard, director of the Research Division. Mr. Josie was assisted by Charles B. Walker of the Research Division who had a major responsibility for the field work and coding of the data and who also served as one of the observers. On the recommendation of the Canadian Nurses' Association, Mrs. Marion Botsford was engaged by the Research Division as nursing research assistant for a period of three months.

The main study is a time analysis of head nurse activity, taking into account factors affecting these activities, such as locale, other persons concerned, equipment and supplies (particularly as related to paper work), and procedures involved. The study was thus designed to be more than a job analysis.

Since the project was of the nature of a pilot study, the report will be of wide interest to all Canadian hospitals. It contains much factual information liberally illustrated with many graphs and the findings are summarized in statistical tables. The Department of National Health and Welfare has sent a copy of the report to the secretaries of all provincial hospital associations and Catholic hospital conferences. Copies are also available from the library of the Canadian Hospital Association and from the offices of the Canadian Nurses' Association.

A Standard of Excellence in Patient Care

K. E. Hollis, M.D.,
Toronto, Ont.

HOSPITAL accreditation is not a new undertaking. In 1917, the American College of Surgeons realized the urgent need for improvement in the facilities provided in our hospitals for the care of the sick. Much preliminary planning and organization, of necessity, was required to launch a program which was to establish minimum standards for hospitals—hospitals which had operated free from any outside surveillance and without a chart or objective that would boost them to higher standards and greater achievements in their humanitarian endeavours.

The need for such a program can be readily appreciated when you are reminded that, in the first year it was in operation, out of 692 hospitals of 100 beds and over, only 12.9 per cent could meet the minimum requirements as drawn up by the first committee on standardization.

The surveying of hospitals was carried on from 1918 to December 6th, 1952, by the American College of Surgeons. Through this service, the College has contributed greatly to the establishment and maintenance of a high standard of treatment and care in the hospitals throughout Canada and the United States. As of December 30th, 1953, over 2,800 hospitals were fully approved, on the basis of minimum standards far higher than the original requirements.

When the American College of Surgeons found it impossible to continue to carry the program alone, five incorporated bodies, vitally interested in the health problems of our countries, pooled resources and personnel and formed the Joint Commission on Accreditation of Hospitals. The participating organizations are the American Hospital Association, the American College of Surgeons, the American College of Physicians and the Canadian Medical Association.

To consolidate the interest and efforts of Canadians in this program, a Canadian Commission on Hospital Accreditation was established. The participating organizations of the Canadian Commission are the Canadian Hospital Association, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and L'Association des Médecins de langue française du Canada. The Canadian Commission is primarily interested in hospitals in Canada but to assume the full financial burden of accreditation of hospitals in this country, at this time, is impracticable. Our Commission works in close co-operation with the Joint Commission in Chicago and Canada is well represented on that Commission. The Canadian Commission has appointed two field representatives who will visit as many hospitals, already approved or seeking approval, as possible.

Some hospitals in Canada will still be surveyed by field representatives from American member organizations. Hospitals with cancer clinics will be surveyed by representatives from the American College of Surgeons. Mental hospitals will be visited by surveyors from the American Psychiatric Association. Other hospitals, because of the co-operative program with our American friends, may be visited by a representative of the Canadian Commission or a representative of one of the participating American associations.

The Author

Every survey report, no matter who makes it, is sent to the office of the Joint Commission for evaluation and subsequent accreditation, or non-accreditation, by the Board of Commissioners of the Joint Commission. The result of the assessment, made by the Joint Commission, is sent direct to the hospital concerned.

What is "accreditation"? Its basic purpose is to assure that the patients in our hospitals get the best possible care that can be given by modern medicine and therapeutic facilities, in association with good organization. Dr. Gunnar Gundersen, La Crosse, Wisconsin, the first chairman of the Joint Commission, elucidated the organization and opportunities of this joint effort on accreditation when he said: "It is a voluntary movement representing the best thinking and best inspiration of five of the most powerful groups in the world dealing with health . . . We recognize what this will mean to the care of the sick and injured of two friendly nations . . . If our duties are discharged well, the benefits to mankind through our profession, through our hospitals and for our civilization are unreckonable."

The question is sometimes asked of the field representative: "Is it worth our while to go to all the trouble of meeting the requirements for accreditation?" The reply to such a question should be: "If you are sincere in your work and true to your professional obligations you should deem it a privilege to be associated with any

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Dr. Hollis, formerly superintendent of Sunnybrook Hospital, Toronto, was appointed as a hospital surveyor by the Canadian Commission on Accreditation. Together with Dr. J. J. Laurier, Montreal, he began field work last April.

program that gives better treatment to your patients and greater service to your community". In making the minimum standards of the Joint Commission *your* minimum standards, you are subscribing to the considered opinion and advice of all the most outstanding workers in the hospital field today.

Benefits

What are the benefits to be derived through accreditation?

To the Patient:

1. Assurance of the best possible treatment through a competent staff and adequate diagnostic and therapeutic equipment.
2. An accurate and invaluable record of an illness.
3. Shorter hospitalization through efficiency, professional skill, and proper organization.

To the hospital:

1. Fewer administrative problems because of good organization.
2. An appreciation of the best standards of patient care and how to provide them.
3. An institution that attracts better nurses and better interns because of its good organization and educational program.
4. Greater confidence and respect on the part of the public.
5. A skillful and ethical professional staff.

To the doctor:

1. Assurance of a good physical plant in which to work.
2. Good diagnostic and therapeutic equipment.
3. Qualified technical personnel.
4. Proper recording and indexing of all case records.
5. Scientific conferences.
6. The professional status of being on the staff of an approved hospital.

How to Apply for Accreditation

How can a hospital obtain these benefits for itself, its patients, and for its medical staff? When an institution believes that its organization can meet the requirements of the Joint Commission, the administrator makes application for accreditation to the office of the Commission at 660 North Rush Street, Chicago. In requesting accreditation it is assumed that the governing board, the medical staff, and the administrator are interested in efficient organization and a high standard of treatment; and that all, for it is a joint effort, desire to meet and maintain the required standards of the Joint Commission.

Upon receipt of an application, the Commission will send a questionnaire to the hospital and from the answers returned will determine the hospital's preparedness for accreditation. As a result of your personal assessment, one of three courses will be followed: (a) a field representative will be sent to make a survey and report the findings, or (b) certain obvious deficiencies will be pointed out with suggestions that they be corrected before a survey is undertaken. The third course (c) would be to offer the assistance of a surveyor, when one is in your vicinity, to advise on your problems.

The approximate date of the visit of the field representative is made known in advance, with the request that certain statistical data and other material be readily available. The latter would include the constitution and by-laws of the hospital, rules and regulations for the medical staff, minutes of all staff and clinical meetings with record of attendance, applications for appointment to the medical staff, and copies of any monthly or annual reports you may have.

About six years ago, the "point rating system" for the evaluation of hospitals was adopted. Prior to this a narrative report was submitted by the surveyor. The former method has proved very satisfactory and gives a uniformity of evaluation which is desirable.

Requirements

To qualify for accreditation a hospital must maintain eight essential divisions, *i.e.*: physical plant, administration, medical staff organization, medical record department, clinical laboratory, x-ray department, nursing service, and dietary department.

In addition to these, there are eight complementary and service divisions which may or may not be organized: the medical department, surgical department, obstetrical department, anaesthesia department, physical medicine department, pharmacy, out-patient department, and the medical social service department.

Briefly, the first essential division takes into consideration the buildings, their functional adaptability, their state of maintenance, and the adequacy of the fire protection. The second division takes into consideration the administration, which includes the board of governors and the administrator—their appreciation of responsibility and interest in the operation of the hospital. The next two divisions are considered most important by the Joint Commission and, accordingly, are assigned over 50 per cent of the total points for the essential divisions. Strangely enough, it is in these divisions that one so frequently finds deficiences. It will be appreciated that a firm medical staff organization is essential if the benefits enumerated above are to be obtained. The organization must be active and in keeping with the requirements of the Joint Commission and not merely a paper organization. The medical records department should not be simply an index of identification data which it will be if proper clinical records are not provided by the doctors, consultants, laboratories and other service departments. The material in this department is a strong evidence of the standard of service to the patient, is a cue to the keenness of the medical staff in practising scientific medicine, and should provide information for research and training.

When a surveyor inspects a hospital he actually spot-checks current and filed case records. He discounts sketchy clinical notes and the use of general uninformative words, such as "normal", "negative", "typical", and other equally ambiguous terms. He looks for the frequency of post-operative infections, checks pathological findings with pre-operative diagnosis, the frequency of consultations, the percentage of Caesarian sections, and other information which might reflect the standard of treatment in a hospital.

An active medical records committee will do much toward assuring good records. The administration can often assist in this phase of the hospital work by providing recording equipment at one or more central locations to facilitate prompt dictation and recording of clinical notes.

The clinical laboratory and x-ray services are essential to all hospitals. The extent to which laboratory procedures are carried out on the premises may vary with the size of the institution but where laboratory facilities are not complete, satisfactory arrangements must be made with an outside laboratory where chemical, bacteriological, pathological, and serological examinations can be made. The

(Concluded on page 80)

What does the administrator look for in a good trustee?

WHEN TWO people pool their ideas on a certain subject, the results should be doubly good—and usually are. Proof of this was offered by R. Fraser Armstrong, superintendent of the Kinston General Hospital, Kingston, Ont., and J. Douglas Winslow chairman of the board of the Carleton County Hospital, Woodstock, N.B., at the Maritime Hospital Association Convention, held at St. Andrews-by-the-Sea, last June. Of interest to all, their remarks were presented in dialogue, generally, as follows. (Edit.)

A: In this discussion, it might be sufficient to say, in just a few words, that the administrator is looking for a trustee who is an able "square shooter", with a broad and progressive perspective towards hospital service. But, before even looking for the "square shooter", should we not have a clearer idea of what "hospital service" entails?

W: In other words, you feel that we had better take a look at the objectives and then discuss the qualifications needed to reach those objectives. What do you consider are the objectives of good hospital administration?

A: The objectives could be detailed at some length. In effect, they are: providing a high quality of care to a patient, participating progressively in health education and research, and keeping the avenues of communication open between all interests associated with the health and welfare of our people.

W: You did not mention the successful financial operation of the hospital. Did you avoid that purposely?

A: No—for there is an obvious relation between sound finance and objective attainment. The administrator looks for those qualities in a trustee which contribute to the attaining of the objectives. These qualities include sound judgment, financial ability, and a contribution to the happy background of administration, which is so necessary for efficient operation.

W: That brings up the ways and means of obtaining the best type of trustee. What are the usual methods?

A: There are several methods. One is based upon the concept that the hospital corporation will be a self-perpetuating body.

W: I assume you mean that when, for some reason, a vacancy occurs in the board of trustees, the trustees themselves would appoint a person to fill the vacancy. I can see dangerous possibilities in that policy.

A: You are right. The policy might lead to complacency in an administration which gets more and more out of touch with the needs of the community. On the other hand, within limits, this policy has points in its favour. Able men like to be associated with each other in a congenial working environment. Their choice of a new man on the board could, therefore, be a very wise choice and, after all, happiness is an essential background if administration is to be as efficient as possible.

W: I understand that some districts form a community hospital association and that this association becomes a group or pool of persons from which the hospital trustees are elected. What do you feel would be the possibility of getting trustees of quality under that policy?

A: The probability is that you will obtain trustees who would be aware of community needs. On the other hand, those trustees might be elected because of popularity rather than their fitness for the task. The process of obtaining members for the community association would also have to be planned with caution. It should not be possible for a special group to "load" the community association with their members and thereby get control of the hospital.

W: What do you think of appointing trustees from various interested groups who would represent those interests on the board?

A: As a matter of principle, it is not good to have a trustee feel that he is representing a special interest. Good trustees, however, have been appointed under this policy. If the trustee is big enough to function in terms of the good of the hospital as a whole, there are certain advantages in knowing the viewpoints of his particular group.

R. Fraser Armstrong, F.A.C.H.A.
J. Douglas Winslow

W: You do not absolutely condemn nor endorse any one of the three policies. Have you any preference?

A: Frankly, I do not feel that any one of the three policies should, in itself, be applied totally. I favour a policy whereby a percentage of the trustees is obtained under each of the three policies we have discussed.

W: Why?

A: The hospital is a complex organization. The board of trustees should be composed, therefore, of persons who have a variety of qualifications. There are, of course, no two identical persons and, possibly, under any policy there would be different results. What is necessary for the board of trustees is the best possible balance of personal qualifications and the best possible contact with the community. This balance and contact would seem to be attained when there is an opportunity of judging the qualities displayed by groups of different viewpoints.

W: What about a medical man being on the board? I understand that not all agree with that policy.

A: I am familiar with reasons for that opinion. However, I have been responsible to boards which include a president of the medical staff. On the whole, his presence has been found helpful. I would, therefore, favour the inclusion of a medical man on the board, preferably the president of the medical staff. I do believe, however, that there should be a clear understanding, at the time of the appointment, that this man is a member of the board responsible for the good of the hospital as a whole and not sitting on the board as a representative of the medical staff.

W: Do you feel that a board member should be chosen for his proficiency in some speciality? I think of accountants, engineers, ministers, social workers, et cetera.

A: No. The qualities we look for in a trustee are based upon broad and general characteristics—a progressive attitude, initiative, good judgment, proper approach to sound decisions, loyalty to the hospital, a person worthy of the community's respect, and generous in attitude towards the executive administration.

W: Are basic qualities more important than proficiency in some specialty?

A: A person can be most efficient with respect to one particular specialty and most inefficient in the broader sense, if the single proficiency obscures his or her perspective in other matters.

W: Do successful business men make good trustees?

A: A successful business man has many of the qualities required for a good trustee. In addition to the qualities, however, which have helped him to surmount competition, there should be the kindlier instincts, a generous attitude towards people, and a keen realization of the objectives of the hospital and of hospital relations.

W: Do you suggest that the environment of business is a selfish one in contrast to hospitals?

A: No, the hospital environment holds no monopoly on the concept of unselfishness. The objectives in business and in the hospital field both include the attainment of respect. On the other hand, the business man deals with people when they are well; in the hospital, the trustee is largely concerned with people who are sick. In the business world there is the board of directors and the executive organization. These two bodies exist in the hospital, too, but the board of trustees has many partners who are associated with the care of the patient. One of the most important partners is known as the medical staff. Relations with the medical staff are most important, although sometimes difficult for a business man to understand. The business man employs his workers under salary—that gives him direct control. It is different with the medical staff in the hospital since they serve voluntarily. While the board is recognized as the ultimate authority, there is no layman who would want to tell or who could tell a physician what medicine is to be given to a patient. The control of the medical staff is necessarily a remote one, accomplished largely through application of medical by-laws and understandings. The avenues of communication become tremendously important. The trustee for whom the administrator looks is the one who has the basic qualities of the successful business man who can orientate himself to the relationship within the hospital.

W: There are certain intangible qualities which are helpful to the administrator. What about community respect?

A: The respect that hospital workers have for a trustee is not based entirely upon how the trustee carries on in the hospital. It is based upon his standing and acceptance in the community. There is sensitivity on the part of all workers to the general qualities of the trustees. These qualities are discussed in the employees' homes and with their friends and associates. If the home judgment is favourable, a tremendous employee respect develops which spreads down through the organization and has a very beneficial influence on hospital-employee relations. One of the qualities that the hospital administrator looks for in a good trustee includes a successful and respected participation in community interests outside the hospital.

W: On what basis would you, as an administrator, like to work with a trustee?

A: There should be a clear understanding of what features constitute "policy" and what constitute "execu-

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U. of T. Administration Students Enjoy Guest Lecture

Students in hospital administration at the University of Toronto enjoy lectures presented by members of the Workmen's Compensation Board, who are seen in the foreground, left to right: A. B. McCartney, William Kerr (standing), and George King.

About the table, from the left, are: Eugenie Stuart, Reg.N., M.H.A., associate professor; Dr. David H. M. Hall; Donald L. Laughlin; Alfred S. Zurkowski; Dr. Robert F. Ingram (seated against the wall); Robert J. Cameron; Albert Nantel; Luigi A. Quaglia; George Reisz; Miss H. Anita Soni; Sydney J. Parsons; and Jack R. Hagerman.

Patients and Books

NEARLY EVERYONE, at some time in his life, has been ill in bed. For many people this inactivity has been difficult to endure. The hours drag interminably. How many of us have found that time passes much more quickly when we are absorbed in an interesting book. Quite often we forget our ills and, for a time, are transported out of ourselves. To how much greater extent would this be true for people who are hospitalized for any length of time! Of course, this does not include the patients who are critically ill. All their strength must be concentrated on getting well. But in hospitals today there are many patients who could benefit from book service.

The patients' library at Sunnybrook Hospital (D.V.A.) is a branch of the Toronto Public Library. A large extremely attractive room, with adjoining sunroom, has been set aside on the first floor for the library. The initial stock of books and the furniture was purchased with money raised by the Gyro Club of Toronto. The Club also gives $500 per year for new stock. This does not cover the cost of new books but it certainly is a tremendous help.

The library staff at Sunnybrook Hospital is employed by the Toronto Public Library. At the New Mount Sinai Hospital, Toronto, the Toronto Public Library has put in a deposit of books. This is administered by the women's volunteer service organization. The organization keeps its own records and pays for any book which might disappear. The latter service has only been functioning about a year but appears to be quite efficient and successful. At many hospitals, libraries are started by volunteer organizations.

Medical Library

Medical libraries are perhaps more commonly associated with hospitals than are patients' libraries. In some cases there is an attempt to combine them under one staff. Today, with the tremendous out-put of medical literature, storage space soon becomes a problem. Then, if the journals and books become scattered, the task of accurate supervision becomes acute as no collection of books and periodicals can be called a library unless it is properly organized.

At Sunnybrook Hospital the content of the medical library is the responsibility of the medical staff and the federal government pays for its books and periodicals. We, of the library staff, however, look after the collection, catalogue the medical books, and keep the records of journals and books borrowed. Since we are not medical librarians we do not search for material. This is carried out by the doctors themselves. However, we do borrow journals and books extensively from the library of the Academy of Medicine, Toronto, and the University of Toronto Medical Reading Room. Both of these libraries have been invaluable and we lean upon them heavily for research material.

Library service whether or not it extends into the field of bibliotherapy as such makes a recognized contribution towards the well-being of the individual.—
Margaret M. Kinney.

Value of Patients' Library

There are people who question the value of a library and its service to patients. The objective of a patients' library is to furnish recreational and educational material for all patients with the purpose of contributing to their welfare and recovery. When ill, a person tends to feel sorry for himself. Even if the library does nothing else, it serves a worthwhile purpose in helping the patient to forget his ills—at least momentarily. Often, however, a library can help a person keep abreast of the new developments in the field of his work and so he is better prepared to return to his job when well. Naturally, this latter type of library work can only be undertaken when the patient is hospitalized for a long period.

The Approach

The approach of the librarian to the patient in a hospital is very important. One must remember that each patient is an individual and has his personal likes and dislikes. The fact that patients are ill colours their personalities and often those who are charming when well become very crochety and finicky when sick. Occasionally you have your head snapped off for no apparent reason. This happened to me once when I asked a bed patient for his regimental number—he turned out to be a major. This was an unfortunate tactical error on my part. However, our classic example of such boners happened to my assistant. When she asked a patient for his name and regimental number his answer was General ..... . But the general took it in good part and was amused by the incident. Thus it is necessary to keep smiling and use patience and tact.

In some cases the librarian has an added advantage. She is not connected in the mind of the patient with his treatment. Thus she forms a different social contact with the outside world—she is neither another patient wanting to discuss illness nor a relative who perhaps feels obliged to visit and does so as a painful duty. Quite often even if the patient does not wish to take books, we spend some time chatting and perhaps leave a magazine he can peruse.

In the ordinary public library readers are drawn together of their own free will and a general interest in the library can be assumed. However, in a hospital this premise does not hold—no reliance can be placed on the patients' desire to read. Then, too, many people who read merely for recreation sometimes suspect that the librarian is there to educate them or

From an address presented at the nursing administration section of the Ontario Hospital Association Convention, Royal York Hotel, Toronto, October, 1954.

Margaret E. McCuaig,
Librarian in Charge,
Branch Public Library,
Sunnybrook Hospital,
Toronto, Ontario.

improve their minds. Because this attitude is fairly common a librarian must never disparage the type of reading a patient wants. Our personal horror must be supressed frequently. We try to give the man what he wants and then when he has come to trust our choice we can perhaps subtly lead him to new and greener pastures. Occasionally you can wean a man from westerns to biographies of people like Jesse James and historical fiction about the exploration and settlement of the West. This is often very hard work but when it is successful you feel you have accomplished a worthwhile project.

Book Selection

As noted before, sometimes hospital libraries are started by volunteer organizations. But no matter how they are begun, the initial problem is one of finding book stock. Many volunteer organizations get their initial stock through donations of books from friends, clubs, and so forth. In this case much of the material must be weeded out for many people just clear out their attics for such campaigns. In any library the books should be up-to-date and in good condition. There are, of course, people who like the older fiction but the majority seem to want the new books everyone is talking about. Any scientific material, in particular, should be recent. Drives and campaigns to raise money to buy books are a much better source of material. In this case buying can be more selective. An annual appropriation is of course the most satisfactory source of funds.

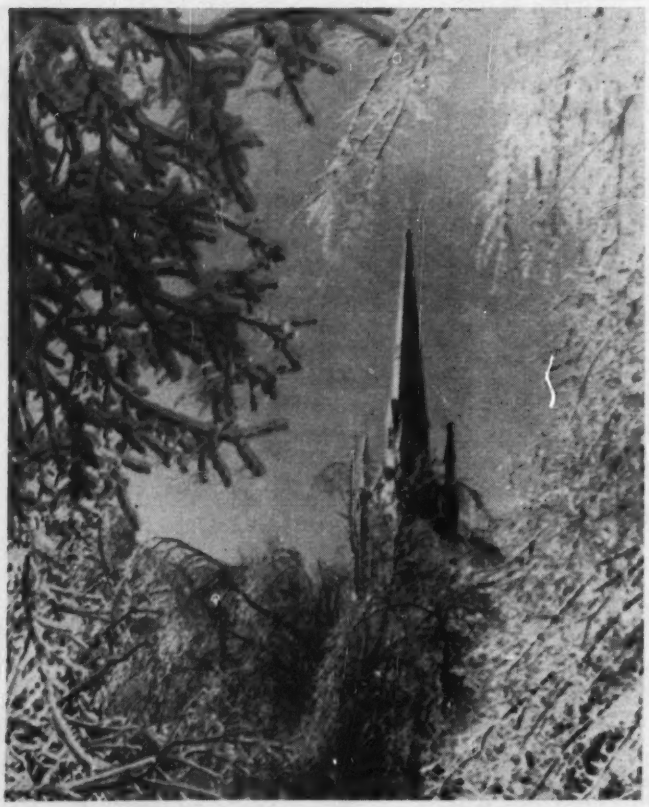
Book selection plays an extremely important role in the life of a hospital librarian. Here the problem of censorship enters. Whereas in a public library books may be chosen chiefly on the basis of their appeal to the library patrons, in a hospital library therapeutic benefit to the patient's health must be considered as well. The printed word can influence a person's attitude and, in some cases, make him change it. But there are no values by which literature may be judged that are absolute for all time. Some restrictive recommendations merely reflect the private prejudices and tastes of the person who makes them and would not necessarily apply to everyone. Since Sunnybrook is a veterans hospital it follows that our books are selected with the interests of the men to the fore.

Bibliotherapy

There has been a tremendous amount written lately on the subject of bibliotherapy. Dr. Alice J. Bryan defined bibliotherapy, in an article in *Library Journal*, 1939, as "the prescription of reading materials which will help to develop emotional maturity and nourish and sustain mental health". Most emphasis on bibliotherapy is found in the description of the use of books in neuro-psychiatric hospitals and the most conclusive reports have been made by psychiatrists who have begun to use literature to help some of their patients. So far most librarians have limited their observations to a few cases in which the patient has commented upon how much good the books have done for him.

Some people feel it is unnecessary to prohibit a certain book to a patient since he will usually find in it what he wants to find. However, this is not the attitude of others. Leroy R. Bruce, in an article in the *Special Libraries* publication, said "that to permit patients to read anything and everything regardless of their condition without the supervision and direction of an expert is like allowing a diabetic to choose his own diet and eat indiscriminately". Thus in some cases, it requires a certain amount of ingenuity to reconcile these ideas of bibliotherapy with what the patient wants to read. In hospital library work one must remember one is dealing with mature people with well developed habits and established tastes about reading or not reading. In a newspaper not long ago I noticed a letter from a woman who had been ill for some time. She stated that she found reading a necessary food and that, although she had been alone for many years, she was not lonely as she had so many friends in her beloved books.

Since there is a neurological wing at Sunnybrook there are certain books, especially very depressing ones, which would not be suitable for these patients



"Silver Spires"—Photo by J. D. Bricker, M.D., Toronto.

to read. But many of these men are up patients and so can and do come to the library to choose their own books. In such cases certain books should not be put on the shelves. Obviously books containing stories about inmates in insane asylums should not be handed out indiscriminately. The few psychology books we have are extremely elementary and I do not think they could harm anyone. It is surprising the number of men from the neurological wing who wish to read psychiatry.

It is very difficult to say with any certainty what will depress a person. You will have as many reactions as you have patients. One case I remember well concerns a book by Peggy S. Curry entitled, *Fire in the Water*. I read it with enjoyment. It is the story of a modern fishing village in the highlands of Scotland. A slightly dour Scottish atmosphere pervades it and you do find a small element of what Hugh MacLennan in the prologue to *Each Man's Son* calls, "an ancient curse intensified by John Calvin and branded upon their souls by John Knox and his successors—a belief that man has inherited from Adam a nature so sinful there is no hope for him and that furthermore he lives and dies under the wrath of an arbitrary God who will forgive only a handful of His elect on the Day of Judgment". One patient, an arthritic and not a Presbyterian, found the book so depressing he could not finish it. Two others, a man and a woman enjoyed it, one even going so far as to call it a "cracking good story". This demonstrated to me the fact that a patient's reaction will not necessarily parallel my own.

We avoid books which have gruesome descriptions of operations or vivid details about the course of any special disease or which disparage the medical or nursing profession. On the other hand we cannot have only books which are humourous, gay and amusing or the pure escapism of the western or detective story. In fact, there are some patients who do not like this type of literature at all. They prefer gloomy books when they themselves feel miserable. One patient can be quoted as saying: "It depresses me to read about happy people when I am sick. Give me a gloomy book with an unhappy ending. I feel better when I read about someone in a worse situation than mine".

Of course you will find those who prefer material in a lighter vein. Personally I know when I feel ill, I choose to read humour or detectives. It is interesting sometimes to watch how a patient's reading habits change as he begins to feel better and takes an interest in his surroundings once again. In some cases, he may start off with a western and end up reading better novels, biography, or travel. In other cases no change occurs—once a western fan always one. We have one patient who takes about eight detective and western stories a week. As he has been hospitalized for some time our supply has long since been exhausted. Any new ones automatically circulate to him first. However, he cheerfully re-reads many of the books two or even three times.

Individual Selection

A very important part of our task and one which takes considerable time is selecting books for certain patients. These are not necessarily specific requests but they are books we think a man might enjoy. The basis of our choice is what he has read and commented upon favourably and material on subjects we discover he is interested in, gathered from our conversations with him. This is a fascinating job. It is surprising how grateful the men are for this little attention. It pleases them to feel we think of them even when we are not on the ward. Often they say even without looking at the titles "If you picked them they will be alright". Of course we are not infallible and sometimes we slip badly but we keep on trying. There was one patient, a doctor, who was hospitalized for quite a time. After a couple of weeks we were able to find books for him which he enjoyed. He was amazed at this and wanted to know how we could tell that he would like a certain book. In a hospital library it is very important to know the contents of your stock. With so many new books being published it is easy to forget the older ones. Therefore, we put summaries in the backs of the fiction. This is of valuable help when looking for novels for the men.

Lately many men have refused to read fiction and have concentrated on other types of books. We have a fairly wide selection of non-fiction. Many patients who know they are to be hospitalized for a long period often wish to read books on a definite subject, *e.g.*, the development of the English novel, with examples representative of the various periods. Others wish to read only books which deal with their own line of work, whether it be stationary engineering or statesmanship. Since we are part of the Toronto Public Library we can use the services of the Interloan Department for many non-fiction requests. As we are often asked for books which are out of print or for which we ordinarily have little demand, this service has proved most helpful. In the past year we have been asked for books on subjects ranging from the making of lobster pots to comparative religion.

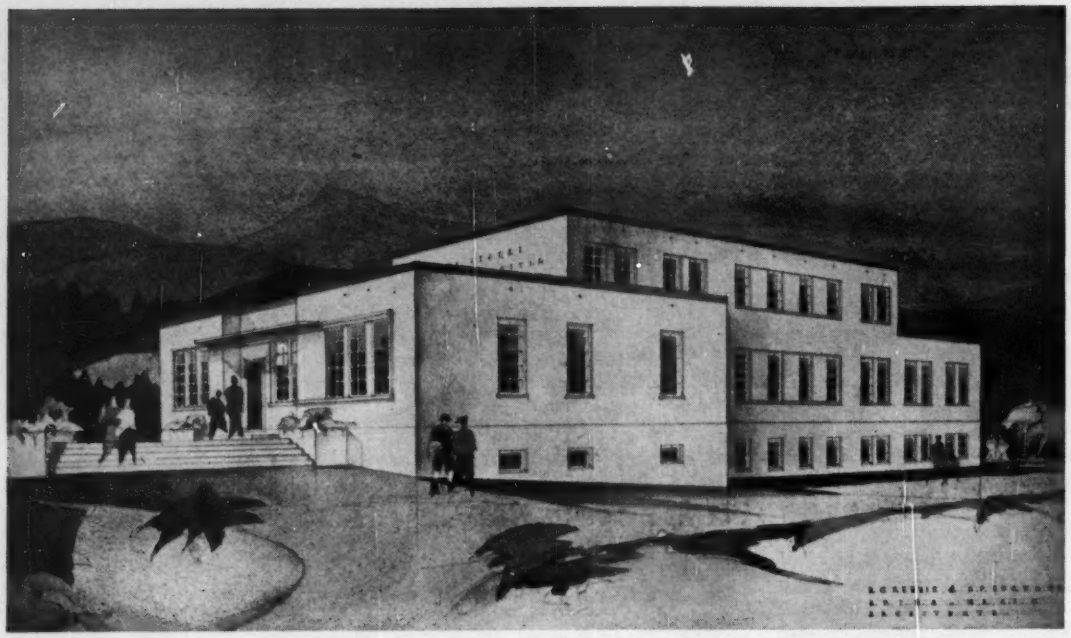
I do not know if all hospital libraries have the same demand for war books as we do. The most popular books in this category are the stories of the underground movement. Often I am astonished at the number of books of this type one man can read without becoming satiated. In fact one chap who had exhausted our supply said "If I ever have to escape I should certainly know how to by this time". You would think that our patients, who are veterans, would have had enough of war but this is seldom the case.

It is my impression that the majority of patients in hospital read approximately the same books as do the ordinary users of the public library. Travel, history, and biography are all popular. So too are historical novels and, of course, the inevitable westerns and detectives. At present sea stories are very popular and at times we are hard pressed to satisfy the demand. We find books containing pictures a help for the men with poor eyesight but who want some material to look at. Copies of *National Georgraphic* are bound and circulated freely. Books of cartoons also amuse many and have been known to lead to book reading.

In addition the library has an electric page-turning machine. It is loaned to the occupational therapy department for patients who cannot otherwise handle books. Each page is clipped and pressure can be exerted by chin or arm to turn them. Although it takes quite a bit of time to set up the book, it is offset by the pleasure a man gets from being able to read. At Sunnybrook it has been used by a patient in an iron lung.

Any hospital library, to function properly, must co-operate with the rest of the staff. In some hospitals the library is under the occupational therapy department. At Sunnybrook we

(Concluded on page 92)



Architects' sketch of the new St. Lawrence Memorial Hospital, St. Lawrence, Newfoundland.

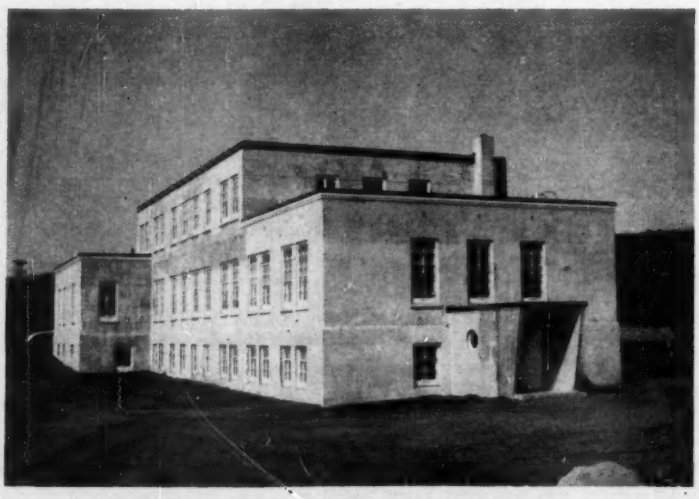
In Gratitude for Heroism

AS THE hardy fishermen and miners of St. Lawrence and Lawn, Newfoundland, come to their new 12-bed hospital at St. Lawrence as patients or visitors, they can regard it with justifiable pride. The hospital is a gift of the United States Government, built to repay a debt incurred almost 13 years ago. In February, 1942, in the midst of a howling snowstorm, two American ships, the U.S. destroyer, *Truxton*, and the cargo ship, *Pollux*, sank off the sheer cliffs near St. Lawrence. Acting as quickly as possible, the residents of St. Lawrence and Lawn braved a raging surf in bitter cold weather to rescue the half-frozen, semi-conscious survivors, who were given shelter and care in village homes. The 182 American sailors who survived the wreck owe their lives mainly to the courage of the villagers and some returned to St. Lawrence last June when the $375,000 hospital was officially opened.

In the new building, patients are accommodated on the second floor, in two 5-bed wards and two private rooms. The nursery contains eight bassinets. The operating room, scrub-up, delivery room, and x-ray unit are also on this floor, as well as the kitchen and dining rooms.

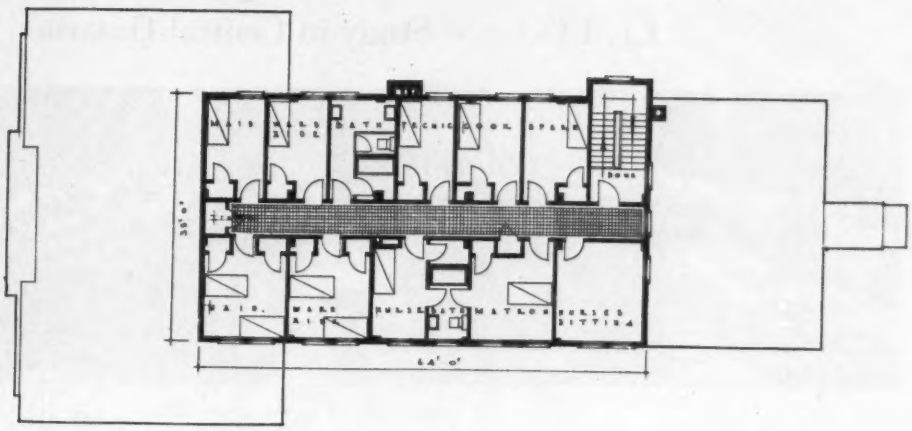
The out-patient department is on the first floor and contains a large waiting room, opposite the doctor's office and examining room. The secretarial office is also located here. The laboratory and dispensary are on this floor, as well as the sewing room and laundry. Ample storage space has been provided for equipment, drugs. and dry stores. On the third floor, there are nine bedrooms for staff, a sitting room, and bathrooms.

The compact, modern hospital fills a need long felt in the area. As the gold-braided admirals, and American diplomats gathered in St. Lawrence last June to pay the villagers honour, their gratitude could have found no happier expression than in the gift they presented.

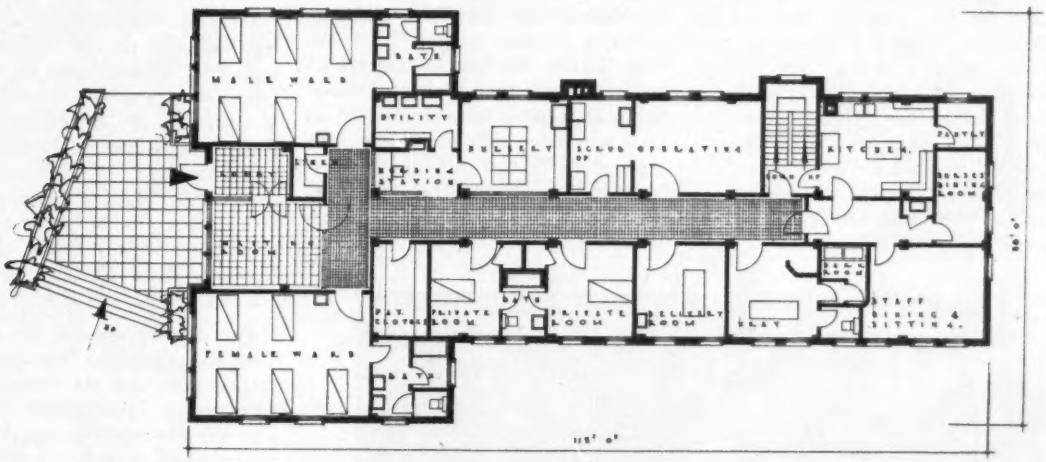


Rear view of the completed building.

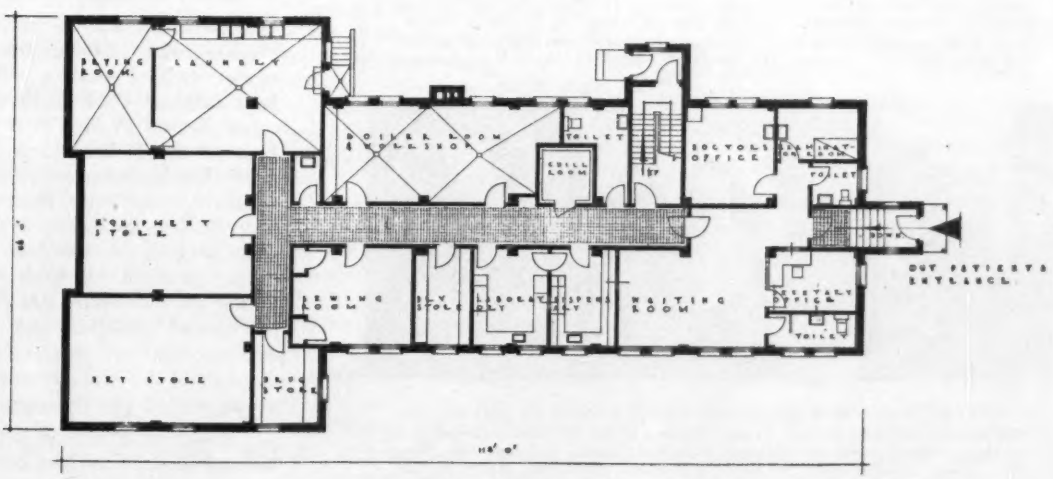
H. G. Rennie,
R. F. Horwood,
Architects.



Third Floor

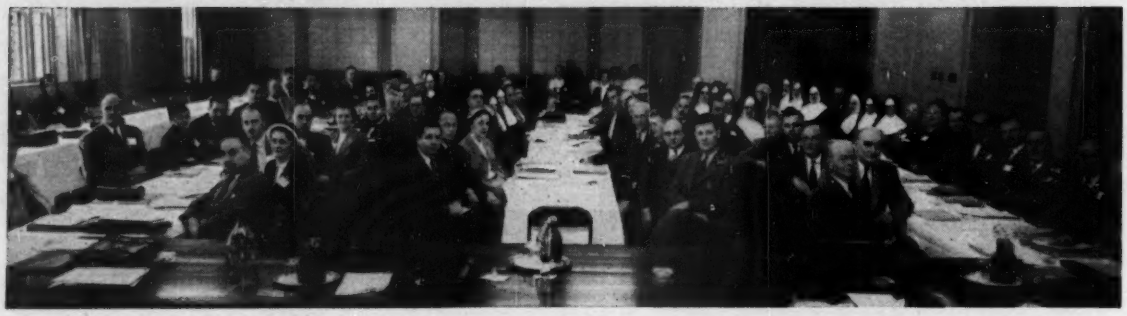


Second Floor



First Floor

Civil Defence Study in Central Ontario



THE CENTRAL Ontario Hospital Disaster Institute was held in Hamilton, December 2nd, and 3rd, 1954. This was the third institute sponsored jointly by the Federal Civil Defence Health Services and the Canadian Hospital Association, previous institutes having been held at Victoria, B.C., and Halifax, N.S., in April, 1954. (See *The Canadian Hospital*, June, page 50.) The Ontario institute also had the active support of the Ontario Hospital Association, as well as provincial and local civil defence organizations.

Highlights of the two-day meeting were the presentation of disaster plans by the Hamilton General Hospital and the Oakville-Trafalgar Memorial Hospital. The meeting was under the chairmanship of Dr. K. C. Charron, principal medical officer, Civil Defence Health Services, Department of National Health and Welfare, Ottawa. Some 23 hospitals were represented by their superintendents, presidents of the medical staffs, and directors of nursing. It is noteworthy that every hospital invited to do so did send representatives. Observers from the Province of Quebec and from hospitals at London, Ontario, were also present, as it is proposed to hold similar institutes in Montreal, Quebec City, London, and Toronto, during this year.

Among those active at the institute were, from left: Dr. W. D. Piercey, Toronto; Dr. R. G. Struthers, Toronto; Dr. K. C. Charron, chairman, Evelyn A. Pepper, J. E. Mathews, and Dr. G. E. Fryer, all of Ottawa. Absent when the picture was taken were A. J. Swanson and Stanley W. Martin of the O.H.A., Toronto.

From the left in this charming group are: Solange Lefebvre, nursing consultant, civil defence health services for Quebec; Thelma Green, consultant, civil defence nursing in Ontario; D.Steele, dietitian, Hamilton General Hospital; Rev. Sister Mary Grace, administrator, St. Joseph's Hospital, Hamilton; Marie Hudson, director of nurses, Hamilton General Hospital; Evelyn A. Pepper, Ottawa; L. H. Parsons, administrator, Oakville-Trafalgar Hospital, Oakville.

Dr. J. B. Neilson, superintendent of the Hamilton General Hospital, presented the disaster plan for his hospital, covering arrangements to handle a maximum of 700 casualties. Dr. Neilson was assisted in the presentation of the plan by Dr. E. C. Janes, chief of surgery, Dr. R. M. Lymburner, chief of medicine, Miss M. Hudson, director of nursing, Miss D. Steele, chief dietitian, and A. M. Keefler, business administrator.

The disaster plan of the Oakville-Trafalgar Memorial Hospital covered arrangements for the reception of a maximum of 75 casualties. Assisting with the presentation were Dr. E. P. Soanes, chief of medical services, Miss L. H. Parsons, administrator, Drs. F. M. Sparling and Campbell MacArthur, and Herbert Merry of the Oakville civil defence organization.

On the morning of the second day, delegates were divided into three groups: medical services under the chairmanship of Dr. G. E. Fryer, nursing services led by Miss E. A. Pepper (both of the Federal Civil Defence Health Planning Services), and administration under the chairmanship of Dr. W. Douglas Piercey of the Canadian Hospital Association. These groups examined in detail the two disaster plans submitted and discussed the method of developing similar plans in their own institutions. The afternoon of the final day was utilized to hear reports and recommendations.

A discussion also took place on the integration of the hospital disaster

(Concluded on page 82)

The Minister reviews national health scene

Hon. Paul Martin, Q.C.,
Minister,
National Health and Welfare,
Ottawa

The publication of a report on an important study directed towards the more effective utilization of limited nursing resources was announced by the Hon. Paul Martin, in the opening address delivered at the Ontario Hospital Association Convention, Royal York Hotel, Toronto, October, 1954.

AT THE request of the Canadian Nurses' Association, the Department of National Health and Welfare conducted a detailed study of the functions and activities of head nurses in a large general hospital. The study, which was carried out at the Ottawa Civic Hospital, was a truly co-operative effort. A number of persons contributed and its successful completion owes much to the invaluable assistance of Nettie Fidler, representing the Canadian Nurses' Association, Dr. W. Douglas Piercey, at that time superintendent of the Ottawa Civic Hospital, and to Edith Young and the senior members of her nursing staff at the Ottawa Civic. The study was under the direction of Gordon H. Josie of the research division of the Department of National Health and Welfare.

A number of interesting facts emerged from the study, indicating that head nurses, whose function should be primarily managerial, are actually spending about 40 per cent of their time on duties which are more appropriate to others on the nursing staff. To illustrate, here are some of the findings:

1. Only about 30 per cent of the head nurse's time was devoted to management and supervision;

2. Execution, or direct activities, which are not so evidently the duties of an administrator, accounted for nearly two-thirds (65 per cent) of the total time;

3. Education or teaching required less than 5 per cent of the head nurse's time.

This study should not be interpreted in any way as a criticism of the manner in which head nurses are utilized at the Ottawa Civic Hospital; indeed, the study was welcomed by Dr. Piercey and his staff, who were anxious to have this minute analysis made in the interests of efficiency there and elsewhere. It is significant that the basic pattern of head nurse activities recorded by this study has been found also in investigations in both England and the United States.

The study was in the nature of a pilot project and the techniques that were developed might well be applied, with appropriate modifications, to the investigation of the duties of other members of the hospital team. Quantitative standards for the duties and responsibilities of hospital staff are essential for the most effective use of available personnel. The Ontario Hospital Association might appropriately consider what it can do in this area, for it is uniquely qualified to make a real contribution.

Hospital Administration

This study is but one example of the critical approach which is now being made to the complex problems of hospital administration. Under the National Health Program, a number of provinces have undertaken hospitalization morbidity surveys. The results of such a study in the province of Ontario were announced recently and have attracted wide interest among hospital administrators and the public at large. Because the *Ontario Hospitalization Morbidity Study* has such a close bearing on the problems of hospital utilization and the rising costs of hospital care, it was gratifying to me that the federal government was able to provide a grant of $57,000 to finance this important project.

Hospital administration has become big business in Canada. It is estimated that the hospitals of this province alone have a capital value of about half a billion dollars and that their expenditures now exceed $115,000,000 a year. This underlines the heavy responsibility that is placed on those in charge of hospitals to ensure that these valuable resources are used to the very best advantage.

Today, a great many Canadian hospitals still have waiting lists of patients seeking admission. It is very easy to conclude that this condition can only be remedied by the construction of more and more hospitals. It should be remembered, however, that since the inauguration of the National Health Program in 1948, over 700 hospital construction projects have been undertaken with the aid of federal and provincial grants to provide an additional 63,000 beds, of which about one-third are in Ontario.

Because of this program, there has also been an impressive expansion in public health services that, in every community, have the hospital as their centre. In view of this, it seems to me that the time is rapidly approaching when less emphasis might be placed on the construction of new hospitals and more attention given to the effective utilization of existing hospital facilities.

No doubt, many patients now in hosptial could be discharged if suitable supervised home care could be provided. Other active treatment beds are occupied in many cases by long-stay patients who might be cared for in less-expensive facilities, thus releasing needed accommodation for the acutely ill. In addition, there must be numbers of patients now hospitalized for diagnostic purposes who would not need to be admitted to hospital if more exten-

In the absence of the Hon. Paul Martin, who was called to New York on a United Nations assignment, his address was read by Dr. G. W. D. Cameron, deputy minister (health), Department of National Health and Welfare, Ottawa.

sive x-ray, laboratory, and other facilities were available for the diagnosis of illness outside the hospital. The new laboratory and radiological services grant is encouraging the development of such facilities.

Shortages in hospital accommodation seem to follow much the same pattern as shortages among trained nurses. The proportion of young women enrolling in nursing schools seems to remain fairly constant and the shortage appears to be caused rather by our rapidly expanding health services and the increasing demands they make on the available nurses. Similarly, hospital construction in Canada, particularly during the past six and one-half years, has been tremendous but there has been a corresponding growth in the uses to which hospitals are being put.

More than ever before the hospital has become the focal point of all our efforts to provide adequate health services for the people of Canada. As a result, the administrative complexities of hospital operation are constantly growing. In terms of physical value and of their potential for service, our hospitals are among the most precious health assets we possess. I am sure that every responsible hospital administrator is eager to see these valuable resources used to the very best advantage.

Three Problems

There are many problems currently facing the modern hospital. I would like to discuss briefly three of these which will continue to challenge the best efforts of hospital administrators for some time to come:

(a) First, with the rising costs of hospital care, there is a real need to continue the improvement of efficiency in hospital management.

(b) Second, I would suggest that more thought could be given to providing special accommodation for particular groups of patients, such as the chronically ill.

(c) Finally, the hospital should accept its full responsibilities in the health field and should place increased emphasis on the needs of its out-patient services and other health facilities.

Management Efficiency

Over the years, Canadian hospitals have built up an enviable record of humanitarian service to their patients. We have every reason to be proud of the high standards of technical skill and of the high levels of efficiency that are general in most Canadian hospitals. It has been particularly encouraging to note in recent years the increasing recognition by hospital boards of the importance of sound business procedures in hospital management. This has been reflected in the wider employment of specially-trained hospital administrators and the more general adoption of standardized accounting and reporting procedures.

In this connection, one of the outstanding achievements of the National Health Program is the improvement of hospital administration through the establishment of construction standards and the provision of special training for a variety of hospital staff.

The efficient operation of a hospital requires not only the professional skills of medicine and nursing but also the administrative skills of management in a highly specialized area. It, therefore, seems logical to conclude that by bringing persons specially-trained in administration more and more into the hospital management field, it will be possible to maintain high standards of efficiency while, at the same time, conserving the professional skills of physicians for medical work.

Care of Chronic Patients

A second problem is the care of special groups, *e.g.*, the chronically ill. With the gradual aging of our population, as the communicable diseases of childhood and early life have been brought progressively under control, the number of older patients suffering from long-term illnesses has steadily increased. To encourage the construction of facilities for chronic and convalescent patients, the National Heatlh Program set a premium on the provision of this type of accommodation by authorizing grants of $1,500 per bed instead of the customary $1,000 provided for active treatment beds.

While encouraging progress has been made, I can say quite frankly that it has been a source of some disappointment to me that less than one bed in twelve constructed under the National Health Program has been for chronic and convalescent patients. And this in spite of the fact that this type of accommodation is usually less costly to build and to maintain.

The Ontario Hospitalization Morbitity Study seems to confirm the belief that the care of chronic patients is making demands on active treatment beds that are out of all proportion to the numbers of these patients. Long-term patients, who, according to this study, made up less than one-sixth of one per cent of the total hospital cases, accounted for more than 10 per cent of the days of care in active treatment hospitals.

I would urge those responsible for the planning of new hospital accommodation to give the most sympathetic consideration to the needs of long-stay patients. Quite apart from humanitarian considerations, the extension of facilities for the chronically ill will ease the demands on regular hospital beds required for the care of the acutely ill.

Out-patient and Other Services

One of the most important aims of the National Health Program has been to encourage the creation and expansion of facilities and services which help to keep people out of hospitals. Probably the most effective way of cutting down the waiting lists for hospital beds is to reduce the need for hospitalization. This can best be done by placing increased emphasis on preventive medicine, by improving diagnostic services, and by developing a more positive attitude towards health generally.

Gradually Canadian hospitals are assuming a more important position in community health activities. Under the National Health Program, assistance has been given for the establishment of out-patient departments or areas within the hospital where out-patients may obtain diagnostic and treatment services. There has been a most gratifying utilization of federal grants for this type of health activity and we hope that this aspect of hospital service will be continued and expanded.

These, then, are some of the problems confronting the Canadian hospital today. I am sure that, with their fine record for assuming each new responsibility imposed on them, Canada's hospitals will be able to meet and master these challenges. In all their efforts, they can be assured of the sympathetic support and whole-hearted co-operation of public authorities at every level of government and of the public they serve.

Humanitarian Purpose

A well-balanced hospital system is essential for any high level of health services. But I am well aware that hospitals cannot be thought of in terms of cost alone, any more than

(Concluded on page 84)

I became a student again

W. C. Hibbert,
Superintendent,
Wadena Union Hospital,
Wadena, Sask.

AS ONE OF the fortunate individuals privileged to take the extension course in hospital organization and management, sponsored by the Canadian Hospital Association, I feel that possibly we, of the first group, may have made some contribution to the course, good or bad as it may be.

After finishing one-third of the first assignments, students in Saskatchewan met with Dr. Peacock, then director of hospital administration and standards of the Department of Public Health. The purpose of the meeting was to express an opinion on what the course offered. We were told to state our opinions, favourable or adverse. Much value was derived, from the opinions of others, as to how they had applied the principles taught in the assignments. Criticism was offered on the volume of reading material required and I was one of those who brought this point forward. I am prepared now to change my mind and will try to show the reasons for this reversal of opinion.

Who is the Course For?

The extension course was planned or designed with a special type of person in mind. The various universities offered post-graduate courses in hospital administration which required a longer period of academic training than many persons in the field could afford to take. Many, also, did not have the necessary background of education for admission to such classes. By far the greater number in the hospital field needed to continue to work to maintain a livelihood for their families but they wanted further education along the lines of their endeavour. This was the gap the extension course was designed to fill. With the assistance of top ranking administrators, the curriculum was drawn up and a course of study established.

What is the Course?

The purpose of this paper is twofold: (1) to show how the course has enabled me to do a better job, helped me with solutions to many problems, and made my position as an administrator so much easier; (2) to draw attention to what this course has to offer and possibly to persuade others to consider studying the same assignments so that they may reap the same advantages.

I can think of no better way to show how this can be accomplished than by pointing out the variety the course of study offers. There are sections on the following subjects:

- Admitting
- Business office procedures
- Business writings
- Dietary service
- Health economics
- Housekeeping
- Laboratory
- Laundry
- Linen Service
- Management
- Medical records
- Medical staff organization
- Nursing services
- Out-patient services
- Pharmacy
- Physical medicine and rehabilitation
- Plant operation and maintenance
- Purchasing and stores
- Radiology
- Social Services

This is quite a list; but you must admit that nearly every one of these sections relates to every hospital no matter how small.

For Those in Small Hospitals

What has the section on management to offer to me, as an administrator of a 58-bed hospital? Prior to my studying this section, there was no formal organizational chart in our hospital. Yes, we understood that the board of trustees was the supreme governing power and that the administrator, superintendent or secretary-manager was the duly engaged representative of the board. We also had department heads, who looked after their departments at the discretion of the secretary-manager. They didn't have much authority, nor possibly too much responsibility. The secretary-manager, if he was efficient, interested, and aggressive, could make a fairly good job of running the show.

After this portion of the course had been studied and the assignments corrected, I set about to draw up a functional organizational chart for our hospital. After consulting with those who were supposed to be in charge, lists of their responsibilities were drawn up and I had to delegate authority. The phrase "span of control" is one I like. Many, as I once did myself, feel that they are able to supervise a number of functions properly. However, now I say that to do justice to any position a limitation must be placed somewhere along the line. The number of hours available in any day is limited, as well as the stamina of any one person. If authority and responsibility are delegated, many small problems can be settled on the lower levels of organization, leaving only the major problems to the administrator as well as the co-ordination of all phases of the operation of the institution. Therefore, I reduced my span of control in order to be able to effect better leadership.

An example of what was accomplished can be shown in the case of personnel relations. In our hospital, there are about 54 employees, any of whom could formerly bring their griefs and problems directly to the administrator. You can readily understand the utter confusion and distraction in which I was involved, as well as the lack of adequate supervision on the job. When employees understood that they must bring such problems to the department head first, the number coming directly to me was reduced and my day became less hectic. This measure also helped to gain the confidence of the department heads.

An administrator should know something about every phase of hospital operation, even a very small one. What better way of learning all the salient features of every department than from lectures and lessons by experts in these fields? What should I know about the laundry? Anyone can

(Concluded on page 72)

From an address presented at the annual convention of the Saskatchewan Hospital Association, held in Regina, Oct., 1954.

Setting up a disease index for the clinical photographer

Anne Elizabeth Rackham,
Children's Hospital,
Winnipeg.

A DEPARTMENT of clinical photography has been in existence at the Winnipeg General Hospital for a number of years; but with the rapid increase in the use of visual education in the medical and nursing schools, and an equally rapid increase in the number of slides in the files, the demands on its resources have been heavy. The original method of indexing and filing became most impractical and unwieldy. The medical record department was asked, therefore, to assist in setting up a more efficient system.

The chief problem was to devise a system whereby a slide could be located by name or by disease as quickly as possible. As the photographic department is not directly connected with the medical record department, nor the staff experienced in medical terminology, it was also necessary to make the disease index as uncomplicated as possible. After studying the needs, consulting with several other hospitals and reading the available literature regarding photographic indices for hospital use, we decided that a system of disease indexing based upon the *Standard Nomenclature of Diseases and Operations* would serve the purpose best.

Requests for photographs or slides usually come with the minimum amount of information. Therefore, we felt that we would need four indices in order to cover all requests as efficiently as possible. These would be: (1) a day book; (2) an alphabetical index of patients; (3) a numerical index; and (4) a disease index based on SNDO.

The alphabetical and numerical indices already in use are on 5" x 8" vertical file cards. We have continued to use them and have made our disease index cards the same size because this is convenient for use and means that the cards can be filed in a standard filing cabinet.

When this article was written, the author was a student at the School for Medical Record Librarians at the Winnipeg General Hospital.

We have made the day book serve as a quick and ready reference source for all work done, as well as a double check in case of loss of cards from the alphabetical and numerical indices. Thus it becomes a permanent record in book form of all photographs taken, with the date, the name of the doctor, any other identification number (Indoor or OPD), the type of picture, and the diagnosis—see Figure I.

Each case is written up in the Day Book as soon as the picture is taken; thus it is also a convenient list from which to obtain the monthly statistics of work done. It is advisable to make a note on the "progress note" section of the indoor chart, indicating that a photograph was taken. Thus, if the clinician is presenting the case, he will know that there is a photo available. In some hospitals a rubber stamp is used for this purpose but, as yet, we have found that a written note is sufficient.

After the film is developed, each print is given a number and this number is then recorded in the day book as well as on the corresponding cards in the alphabetical and numerical indices. However, before assigning a number to a slide it should be determined from the alphabetical index if there has been a previous photograph of the same patient. If so, then the same number may be given to the new slides thus forming a "unit" system of slide numbering and filing. For example, the before-treatment number may be: P-646 a,b and after treatment number, P-646 c,d. This can be very helpful for teaching purposes when it is desirable to show the "before and after" effects of treatment.

The Alphabetical Index—See Figure II

The alphabetical index contains patients' names. The file is composed of the original requisition cards, signed by the attending physician and also by the patient, who thereby gives

(Continued on page 70)

Figure I

Date	Slide No.	Patient's Name	Ref. No.	Doctor	Colour	Size	Diagnosis Other
6/54	P646 a-d	Black, John	OPD6673	White	K	3 mm	Ca. lip

Figure II

File No. .....

Winnipeg General Hospital Medical Photograph Department

Requisition for Photographs or Lantern Slides

Name ..... Age .....

Address ..... Date .....

Hospital Ward ..... Private ..... Semi ..... Public .....

Hospital No. ..... Walk ..... Chair ..... Stretcher .....

Type of Photo: Colour ..... Black and White ..... Movies .....

Clinical Diagnosis .....

.....

.....

.....

Particular features required .....

.....

.....

.....

You may use all photographs for clinical demonstration purposes

Doctor's Signature only—not Intern ..... Patient's Signature .....

Recent Findings in Meat Research

Elizabeth Feniak,
Assistant Professor
of Foods and Nutrition,
University of Manitoba,
Winnipeg.

THE MEAT course, as prepared for one's dinner table, has always demanded a major portion of the food budget allotment for the day or week. Recommendations for the apportionment of the budget suggest 20 per cent or less should be spent on meats. However, one recent analysis of American dietaries indicates that an average of 32 per cent is being spent on this important food group. From an institutional standpoint, the dollars spent by the family for meat are multiplied many times over. Because of this, and because of the fact that to many people "meat makes the meal", it remains a matter of considerable importance that the consumer obtain the greatest possible degree of satisfaction from her meat purchases.

Statistics show that the per capita consumption of meat in Canada during 1953 was 127½ pounds or almost ½ pound daily for every man, woman, and child. This figure includes 59 pounds of beef, 57 pounds of pork, with the remainder made up of smaller quantities of veal, mutton, and lamb, variety, and canned meats. Compared with this, it is estimated that eight pounds of meat or less is consumed annually in the Near East. This is low indeed and serves to emphasize the prominent position of meat in our Western food pattern.

The nutritive contribution of meat includes, in addition to large amounts of high quality protein and iron, significant quantities of B vitamins such as—thiamine, riboflavin, niacin, and pantothenic acid. There is need for more information about the effect of freezing, canning, and various methods of cookery upon the vitamin values of meat cuts. The water soluble B vitamins are lost to a certain extent in the cooking juices. Where the product is braised, the amounts of thiamine and riboflavin in the juices average around 20 to 25 per cent; and thus there is a need to conserve these juices in gravies and soups. Losses due to destruction by heat are appreciable. A wide range of retention values of the B vitamins is reported in the literature, ranging from 32 to 88 per cent for thiamine and somewhat higher for riboflavin and niacin. Losses of thiamine are dependent upon the length of the cooking time and the temperature reached. For example, in one study, round steak fried retained 89 per cent, braised in the oven 38 per cent, and cooked in the pressure saucepan 47 per cent of the original thiamine.[1] Canned ham has been found to retain approximately 43 per cent of the thiamine content, canned beef and veal, 35 per cent or less.

Selecting Meat

Consumers may select beef by grade in Canada. Beef which is government-inspected may be graded red ribbon or choice and blue ribbon or good grade. However, a large quantity of beef is sold without a grade mark, and is of commercial quality. To command the top grade, a cut must come from a well-formed carcass, be of good colour and quality, with a desirable degree of finish, as shown in the marbling of fat throughout the meat, and an adequate cover of exterior fat. Many investigators emphasize that cuts from top grade beef yield significantly higher palatability scores than cuts from a poorly finished carcass. The inhibiting effect of fat particles on the loss of fluid is suggested as being responsible for greater juiciness in the meat when cooked. The distribution of fat also, apparently, bears a relationship to tenderness since the extent of marbling correlates well with the amount of tenderness.

Evidence that the consumer is not always disposed to choose the better grades of meats has shown up in tests of consumer buying habits. When uniform cuts of choice and commercial grade were offered at the same price, greater sales of the lower grade occurred, even though the top grade was selling below its usual market price. Apparently the consumers valued the economy features of a high percentage of lean beef rather than the improved palatability and tenderness anticipated from the better grade.

Studies to obtain more information about that quality of tenderness so desirable for top palatability are reported by many research workers. Tenderness is, of course, associated with the minimum degree of connective tissue as influenced by the age of the animal, location of cut, degree of exercise involved, et cetera. When individual muscles are tested for shear strength, great variation is noted in the tenderness of muscles ordinarily found together in retail cuts, as well as variation in tenderness within the muscles.

The aging or the ripening of beef acts to increase the degree of tenderness due to the action of proteolytic enzymes in the meat. Detailed investigation shows that the effect of aging upon specific muscles is not uniform, although there is a general tenderizing effect up to a period of 17 days. Aroma and flavour, it is suggested, reach their maximum amount in 10 days and decrease considerably with aging periods that are longer than 20 days.

Recommended cooking methods for meat continue to stress low temperature cooking to produce better shape and greater juiciness, as well as to control shrinkage and scorching of drippings. As a matter of fact, prolonged cooking in a low temperature oven has been suggested to be as effective in tenderizing less tender cuts of meat as simmering in water at the same temperature. The pressure saucepan method requires a much shorter cooking time than oven roasting but certain controlled studies[2] have shown that there is no increase

in tenderness by this method but a greater loss in drippings, and a drier and less palatable product.

Meat tenderizers contain an extract of papain, a proteolytic enzyme from papaya, and presumably will tenderize through enzymatic action on the connective tissue. A study on the effects of tenderizing has been reported recently, using paired cuts of steaks and roasts[3]. One half of the steaks were sprinkled with six grams of tenderizer per pound. The meat was forked before and after application of the tenderizer and then allowed to stand at room temperature for one hour for each inch of thickness. Rolled and rump roasts were treated and then allowed to stand either at room temperature for one hour or in the refrigerator for 18 hours. The treated samples cooked more rapidly, probably due to more rapid heat penetration after the forking treatments. The use of tenderizer showed significant increase in tenderness of steaks (as measured by shear values) but no difference in tenderness of the treated roasts. The untreated samples rated lower in scores for juiciness. The judges, however, showed a preference for the treated samples.

Freezing

Freezing has become a popular method of preserving meat and has largely supplanted other methods. Considerable information is being amassed as to the effect of freezing temperatures, packaging, storage length and temperature, as well as other factors on the palatability and retention of nutritive value of the product. There is lack of agreement as to whether the freezing process, as such, alters tenderness.

One of the most important factors in the retaining of quality during freezing is adequate wrapping. The wrapping must be air-moisture-vapour proof to keep any drying of the meat to a minimum as well as the oxidative changes to the fat which would be responsible for a rancid taste and odour. Heavy aluminum foil and cellulose films such as polyethylene and saran have proved to be very effective while freezer locker paper has proved relatively inefficient.

Rate of freezing, although considered important during the early development of freezing methods, has been shown with beef to have no significant effect on palatability factors or alteration of vitamin values. Similarly, different storage temperature ranging from 0°F to 15°F and fluctuating within this range, have shown no appreciable difference in palatability moisture loss, provided efficient wrapping methods are used. The effects of defrosting beef during storage have been studied and results reported indicate that if defrosting temperature is not above 40°F to 50°F and meat is not allowed to remain defrosted for a period of over 18 to 20 hours, no significant deterioration in palatability occurs even after four defrostings. Appearance of the uncooked meat was impaired by defrosting and undesirable flavour changes occurred in ground beef with four or more defrostings.

Precooking before freezing may be done as a time-saving device, or leftover cooked meats may be conveniently frozen. Several comparisons of paired roasts frozen uncooked and precooked show a more desirable flavour and greater apparent tenderness in the roasts cooked after freezing. Greater drip loss occurs with the post-frozen roasts and if roasting is begun while interior temperature of the defrosted roast is still low, thiamine loss may be high due to the longer time required for the roast to reach the desired temperature. The use of aluminum foil wrap has been suggested for the precooking and subsequent cooling, freezing, and defrosting of meat for convenience as well as to protect it against bacterial contamination while it cools and is being wrapped for the freezer.

Pork retains its quality during freezing for a shorter length of time than does beef or poultry. This is because pork fat's greater degree of unsaturation makes it more susceptible to the development of oxidative rancidity. There is lack of agreement among investigators as to the length of time meat will retain quality in freezer storage. No doubt this is partly due to different standards for the measure of palatability and partly due to differences among meats and treatment. Beef has been found to be less desirable in flavour after 12 months of storage. Pork develops a less desirable flavour beyond six or eight months. It has been shown that extended exposure of pork fat to ultraviolet light in the aging room, which is done to minimize microbial growth, causes rancidity to develop much more rapidly during later freezer storage. Certain salts including sodium chloride, apparently also act to hasten rancidity during freezer storage, so that cured salted bacon becomes rancid more quickly than fresh sides of pork.

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1 Tucker, R. E., Hinman, W. F., and Halliday, E. G.: "The retention of thiamine and riboflavin in beef cuts during braising, frying, and boiling", in Jour. Am. Diet. Assoc. —22:877-881(1946).

2 Clark, R. K., and Van Duyne, F. O.: "Cooking losses, tenderness, palatability and thiamine and riboflavin content of beef as affected by roasting, pressure saucepan cooking, and broiling", in Food Res.—14:221-230(1949).

3 Hay, P. P., Harrison, D. L., and Vail, G. E.: "Effects of a meat tenderizer on less tender cuts of beef cooked by four methods" in Food Tech—7:217-220(1953).

Questions on Accreditation

In a recent Bulletin of the Joint Commission on Accreditation of Hospitals, it is reported that many hospitals write in asking for specific surveyors, saying: "Dr. X. understands our problem so well, we want him to do our next survey". No doubt, says the *Bulletin*, that is a compliment to the specific individual named but it is against the purpose and principles of the Joint Commission. Field representatives are rotated through different assignments so that the charge of favouritism and discrimination can never be levelled at any surveyor or the Commission. Specifically, if a certain surveyor is in a certain area one year, the Commission tries to make it a point that he will not return to that same area for the next two or three years.

There is also discussion in the *Bulletin* concerning the question: "How long may a hospital stay provisionally accredited"? The following rule has been passed, and is now a policy of the Joint Commission. This is: "If a hospital with provisional accreditation continues to be provisionally accredited on the second survey, the hospital will be told that it will be surveyed again the following year and if it does not then meet the standards for full acreditation, it will be dropped to 'no accreditation'. This will be conveyed to the hospital in writing."●

Sir Alexander Fleming at St. Mary's Hospital, London, England.

Two great names in a hospital's story

A GREAT AND as yet unfinished chapter in medical progress was highlighted last November when St. Mary's Hospital Medical School in London, England, held centenary celebrations. Here Sir Almroth Wright made revolutionary strides in bringing bacteriology into the service of medicine and his pupil, Sir Alexander Fleming, made his famous discovery of penicillin.

In 1902, when Sir Almroth Wright was appointed pathologist at St. Mary's Hospital, he was already a renowned figure for he had introduced preventive inoculation against typhoid. Lister had made surgery safer, smallpox could be controlled by vaccination, and diptheria treated by serum. For the rest, it was a case of "good nursing" or of "keeping up the patient's strength". No hospital had a bacteriological laboratory and there was little encouragement for scientific workers.

At first Wright's department (too grand a word perhaps) consisted of two basement rooms in which the microscopes quaked at the passing of every underground train. He soon changed that. He gathered some helpers and moved to steadier and more presentable quarters on the second floor. There, quite irregularly, he set up an out-patient clinic, though he was not paid to look after the sick but to teach pathology. He did this because he wanted to pursue an idea he believed would, in time, revolutionize medicine and because he wanted to try out his methods in practice.

Pasteur had successfully inoculated patients against rabies after they had been bitten by mad dogs, after they had begun incubating the disease. Metchnikov, Pasteur's follower, had shown how the millions of wandering cells in the body, known as phagocytes, swallowed attacking microbes. This, he thought, was how the body protected itself against infection. On the other hand, German scientists, like Koch and Von Behring, thought that attacking microbes were destroyed by some power of the blood fluid.

Wright went on to demonstrate that it was necessary for the microbes to be prepared in some fashion or "buttered" before the phagocytes would swallow them. This "buttering", he decided, was done by a property in the blood serum he called opsonin.

"It was a fundamental discovery of the first importance," states Dr. Leonard Colebrook, Wright's biographer, "possibly the most far-reaching since Pasteur discovered that fermentation was due to bacterial action."

The Wright-Fleming Institute.

The serum of a healthy person will allow about the same nmber of bacteria to be swallowed by each phagocyte, while the serum of a person threatened by infection would show a deviation from the normal. By testing a patient's blood under the microscope, his opsonic power or opsonic index could be ascertained and it could then be restored to normal by an appropriate dose of vaccine.

Wright had synthesized French and German theories, had thrown much light on the mechanism of recovery from infectious diseases, had pointed the way to real precision in diagnosis and had opened up a new field in the treatment of many ailments. Moreover, at a time when the taking of a blood sample from the vein was almost unknown, he and his team devised countless technical means which expanded the scope of laboratory investigation.

In fact, he had made one kind of revolution by bringing bacteriology to the service of medicine and by encouraging every large hospital to follow his example and set up laboratories. Attracted by his genius, a group of brilliant young men joined him, most of them destined to win great honour in due time.

Alexander Fleming discovered penicillin in Wright's innoculation department and on Wright's death in 1947 succeeded him as its director. It is now the Wright-Fleming Institute of Microbiology.

Doctors from all parts of the world went to visit Wright's laboratories and some stayed to work. George Bernard Shaw declared he "smelt drama" there and was stimulated into writing "The Doctor's Dilemna". Celebrated men like Ehrlich, Koch, and Metchinkov came to see for themselves what had been achieved.

It was a "great era" in the history of St. Mary's Hospital and its medical school and in Britain's medical history for, with Jenner and Pasteur, Wright had contributed significantly to progress in immunization.—*From an article by L. J. Ludovici, courtesy of the United Kingdom Information Office, Ottawa.*

◂ Health Care Plans ▸

Statistics speak well for Blue Cross

At the annual meeting of the Canadian Council of Blue Cross Plans, held in Montreal, Nov. 24th to the 26th, it was announced that the Plans have paid 3,000,000 hospital bills for Canadians throughout the country, since the beginning of the forties. Covering Alberta, Manitoba, Ontario, Quebec, and the four Atlantic provinces, the Blue Cross Plans have provided 25,000,000 days of prepaid hospitalization. Maternity care has also benefitted, with over 500,000 prepaid Blue Cross babies in Canada.

Over 22,000 Canadian firms now place Blue Cross at the disposal of their employees and their families, through payroll deduction. Adding together: (1) the employee subscribing through company groups; (2) their dependents; (3) the self-employed and the employees of small firms in the areas where such subscribers are accepted individually; and (4) their dependents—there is now a total of 3,200,000 Canadians who have voluntarily enrolled in the Canadian Blue Cross Plans.

The Canadian plans are currently providing 350,000 days of hospitalization per month, paying an average of nearly $4,000,000 per month for hospital care. Each month, some 45,700 Canadians are receiving Blue Cross hospital benefits from the plans —including a monthly average of 7,600 maternity cases.

During a year, 144 members out of 1,000 need hospital care. For families, the proportion is one out of three. Members spend, on the average, 8½ days in hospital during their stay.

* * * *

Traduction

A l'assemblée annuelle du Conseil Canadien des Plans de la Croix Bleue, tenue à l'hôtel Windsor, à Montréal, les 24, 25 et 26 novembre, il a été annoncé que les Plans canadiens de la Croix Bleue ont maintenant payé plus de 3,000,000 de comptes d'hôpital.

Ces Plans, qui couvrent l'Alberta, le Manitoba, l'Ontario, le Québec et les quatre provinces maritimes ont fourni 25,000,000 de jours d'hospitalisation et fourni des bénéfices pour plus de 500,000 cas de maternité.

Plus de 22,000 compagnies canadiennes mettent la Croix Bleue à la disposition de leurs employés et des familles de ceux-ci. 3,200,000 canadiens sont membres de la Croix Bleue.

Chaque mois, les Plans canadiens fournissent 350,000 jours d'hospitalisation, et paient près de $4,000,000 pour soins hospitaliers fournis à leurs membres. Chaque mois, 45,700 membres bénéficient du Plan, dont 7,600 pour des cas de maternité.

Durant l'année, 144 membres par 1,000 vont à l'hôpital. Pour les familles, la proportion est de 1 famille sur 3. En moyenne, les membres passent 8½ jours à l'hôpital durant leur séjour.

* * * *

Ten Years of Service for Maritime Blue Cross

Last fall, the Maritime Hospital Service Association celebrated its 10th birthday with the formal dedication of its new administration building at 110 MacBeath Avenue, Moncton, N.B. The occasion also marked another anniversary—the sixth year of Blue Shield service.

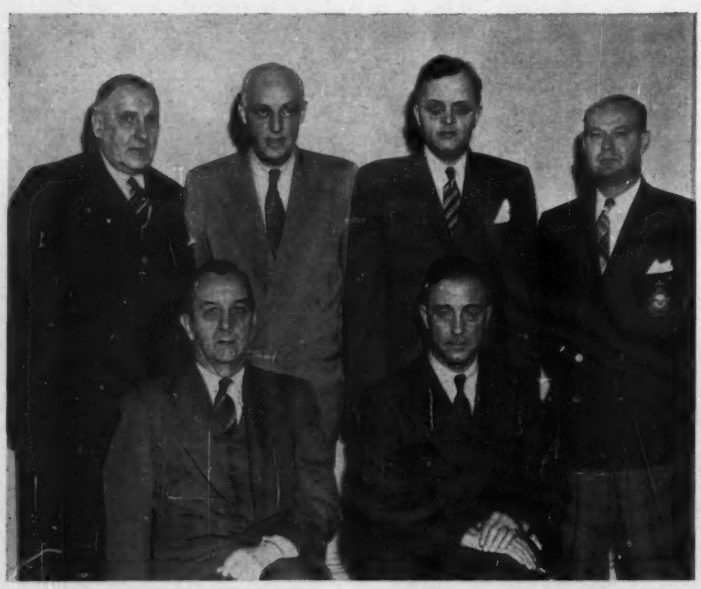
In the modern, two-storey structure, some 150 employees handle an average of 100,000 claims annually, 55,000 of which are hospital claims and 40,000 for medical care. Enrolment in Blue Cross and Blue Shield plans has grown steadily over the years. As of August, 1954, there were 296,134 subscribers in Blue Shield and 166,000 in Blue Cross.

* * * *

Prepaid Medical Care in B.C.

The doctors of British Columbia have formed an organization, known as Medical Services Incorporated (M-S-I), which offers prepaid services to people who become ineligible for coverage under the Medical Services Association (M-S-A), which was established 14 years ago by the doctors of the province. The new association, M-S-I, is approved and recommended by M-S-A. M-S-I is for persons who leave an M-S-A group—those who retire, widows and children of M-S-A members, children who reach their 18th birthday and become ineligible for M-S-A, together with employees who transfer their place of employment.

Coverage includes: medical and



Trustees of the Canadian Blue Cross Plans at the annual meeting were, back row, from the left: A. J. Swanson (Ontario Hospital Association); Dr. D. R. Easton, (Alberta); Darrell Laird (Manitoba); Dr. J. A. MacDougall (Maritimes). Front row, from the left: Dr. O. C. Trainor, Winnipeg; and J. R. H. Robertson, Montreal.

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surgical care in hospital, maternity services, consultations, interpretation of electrocardiographs, anaesthesia services, and emergency medical and surgical care outside British Columbia. For small business groups, employing from three to nine persons, the same complete coverage as in M-S-A is provided. This includes home and office visits. Through inter-plan transfer agreements, persons who move to another part of Canada or the United States can have their membership transferred to a participating plan in the new area, without loss of seniority benefits.

* * * *

One Blue Cross—Blue Shield Plan To Cover Prolonged Illness

(From an article by Charles G. Hayden, M.D., executive director, Massachusetts Medical Service, and Roger W. Hardy, executive director, Massachusetts Hospital Service, Inc., which appeared in "Chronic Illness News Letter", October, 1954.)

It has become increasingly apparent during the recent past that Blue Cross and Blue Shield Plans cannot meet the legitimate requirements of the public with programs that limit benefits to services rendered only in the hospital. While it can be argued effectively that benefits for the treament of minor or self-limiting conditions in the home, office, or hospital outpatient department should be excluded from coverage on the grounds that they are of small economic consequence and can, therefore, be budgeted, it is not possible to apply the same argument to the services required by persons suffering from protracted illness.

Extension of Blue Cross and Blue Shield coverage into the area of prolonged illness is a natural and logical development. Some nine Blue Shield Plans have been experimenting with this type of coverage and a few private insurance companies now are also underwriting this type of risk. It is estimated that from 600,000 to 1,000,000 persons in the United States have some protection against what is commonly called major medical expense.

In Massachusetts, the basic Blue Cross group contract provides full coverage of the so-called ancillary services furnished by hospitals during 120 days per illness or injury. In addition, subscribers may elect $7.00, $10.00, $12.00, or $15.00 credit toward room and board. During the first 60 days of hospitalization full credit at the rate chosen is extended for room and board while half credit is provided during the succeeding 60 days. Blue Shield provides benefits for medical, surgical, and obstetrical services in the hospital and for surgical and obstetrical services outside the hospital. Benefits are also provided for anaesthesia, diagnostic and therapeutic x-ray, and endoscopy. Service benefits are furnished for individuals and families with annual incomes of $5,000 or less which means that for persons in this category the physician accepts the Blue Shield fee as payment in full for covered services. The $12.00 room and board group contract offered by Blue Cross costs $5.00 per family per month. The $5,000 income-limit group contract offered by Blue Shield costs $4.75 per family per month.

The prolonged illness contract recently issued jointly by Blue Cross and Blue Shield in Massachusetts is designed to supplement the coverage provided in their basic contracts. For an additional monthly subscription charge of $1.00 for the individual and $2.00 for the family, it will protect members against most of the medical costs of selected illnesses and injuries until such time as an expenditure of $2,000 to physicians and $3,000 to all other parties has been made. These amounts are in addition to benefits provided under the basic contracts. To be eligible for prolonged illness coverage the member must first have basic coverage under Blue Cross and Blue Shield.

The illness and injuries selected for special consideration under the contract fall into 18 categories which are based to a large extent upon information derived from the Visiting Nurse Association of Boston and persons engaged in operating nursing homes. Although this list is already broad in scope it is hoped that ultimately any condition requiring care after discharge from the hospital, if only for a short period of time as in the case of acute conditions, will be included. The categories are as follows:

1. Poliomyelitis and its late effects.
2. Cancer, including disseminated cancer such as lymphoma, myeloma, leukaemia, aleukaemia, and Hodgkin's disease.
3. Benign neoplasms of the brain or spinal cord.
4. Subacute combined degeneration of the spinal cord.
5. Cerebral haemorrhage, embolism, or thrombosis.
6. Coronary embolism or thrombosis.
7. Subarachnoid haemorrhage.
8. Rheumatic fever or chorea.
9. Congestive heart failure.
10. Active pulmonary tuberculosis with positive sputum or gastric contents.
11. Ulcerative colitis and regional enteritis.
12. Cirrhosis of the liver with ascites requiring paracentisis or following a shunt operation.
13. Chronic nephrosis or chronic nephritis with uremia.
14. Pemhigus.
15. Myasthenia gravis.
16. Amputations where prostheses are indicated.
17. Fractures.
18. Haemiplegia, paraphlegia, or quadriplegia.

Civil Defence in New Brunswick

The province of New Brunswick has become the 7th Canadian province to join the federal government in a co-operative program for extending the nation's civil defence preparedness program. The first project approved under the arrangement calls for a basic expenditure of almost $9,000 for the organization and extension of a civil defence program in the City of Saint John. It will entail the appointment of a part-time civil defence director and a full-time chief warden. The grant also provides the necessary office organization required to activate an effective civil defence program in the city. Two grants, totalling more than $5,000, have been approved for Moncton. They will aid in providing civil defence personnel and facilities, as well as the installation of air raid sirens.

A man's own character is the arbiter of his fortune.—*Syrus*

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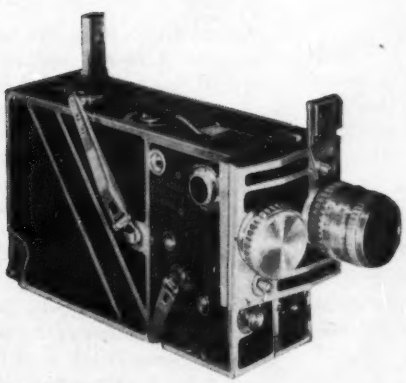

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Provincial Notes

British Columbia

NANAIMO. The Nanaimo Hospital board has increased the rates charged for private and semi-private rooms. The new scale went into effect on November 1st, when daily rates for a private room became $3.50 and for all semi-private rooms, $2.50. Up to November 1st, the rates were $2.50 daily for private and $1.50 for semi-private rooms.

* * * *

NELSON. Property owners gave their endorsement to participation in a city-district partnership for construction of a new hospital in a vote on a money bylaw recently. The largest vote in the 57-year history of the city was reported by which 94.65 per cent of the voters gave approval to the $270,000 bylaw. The approval means that the city will join with the district in construction of a proposed 120-bed city-district hospital. Total investment is estimated to be $1,800,000.

Alberta

CALGARY. Proposed plans for an additional $1,500,000 extension and building program, which would probably be spread over a five-year period, have been announced by the Calgary General Hospital board. The program consists of several projects including the completion of a new 200-bed hospital for the chronically ill. The additional four-point program includes the completion of parking lots and landscaping about the entire hospital area; a waiting room for the Perley Pavilion maternity wing; an office extension of the administrative area; and an extension of the nursing service area.

* * * *

DRUMHELLER. The new annex to the Drumheller Municipal Hospital was opened recently. The one-storey building with a semi-basement was built at a cost of $500,000. Housed in the new addition will be the maternity ward, with 18 cubicles as well as three cubicles in the infectious disease nursery. In the basement is a new laundry and boiler room. Through the addition, 28 beds have been added to the hospital's total capacity bringing it up to 105 beds.

* * * *

STETTLER. A new $250,000 chronic and convalescent hospital was officially opened here at the beginning of November by the Hon. W. W. Cross, M.D., provincial minister of health and welfare. The 32-bed hospital is equipped to care for patients who are not entirely bedridden, in rooms which have single or two beds. All wards and working areas of the hospital are on the ground floor of the storey-and-one-half building, with staff quarters on the second floor. The building was financed on a per capita basis by the town of Stettler and Stettler municipal district, along with grants totalling $3,000 per bed from the federal and provincial governments.

Saskatchewan

ARBORFIELD. The new Arborfield Union Hospital was officially opened in November. A one-storey building, the unit contains 8 beds and is situated about one mile west of the town.

* * * *

REGINA. The Regina General Hospital has been granted $10,500 from the provincial health department for the expansion of its isolation wing, with six more beds for chronic polio cases.

Ontario

BELLEVILLE. The sod has been turned and construction has begun on the new 100-bed wing to the Belleville General Hospital. Estimated cost of the new wing is $1,250,000.

* * * *

HAMILTON. A radio-active isotope clinic, to help in the fight against cancer and other diseases, is being built at the Hamilton General Hospital. The clinic, located in the basement of the children's wing, is expected to be in full operation in a few months. A $200,000 general improvement program is also under way at the hospital. Improvements include expansion of the department of pathology, a new central food service, a new boiler room and facilities for two new fracture rooms.

* * * *

LONDON. The Ontario Cancer Foundation's new clinic at the Victoria Hospital was officially opened in November. This clinic, at the hospital, was taken over by the Ontario Cancer Foundation recently as part of its program to standardize clinics across the province. An agreement between the Victoria Hospital board of trustees and the London City Council and the Foundation, providing for the Foundation to take the clinic over on a rental scheme, has yet to be made official by order-in-council. The clinic is located on the main ground floor of the new "Y"-shaped addition to the hospital.

* * * *

MINDEN. A contract has been let and construction work has started on a Red Cross Outpost Hospital here. A total of some $12,400 has been raised to help toward the cost of construction.

* * * *

NORTH BAY. Plans are being prepared for a 60-bed addition to St. Joseph's Hospital. The extension will be built on the east wing of the present 125-bed building. Present plans call for the addition of 40 active treatment beds and 20 beds for long-term patients. The architect for the new wing is Louis Fabbro, Sudbury.

* * * *

ORANGEVILLE. Despite the nearly $10,000 damage caused by the floods from hurricane Hazel, in October, the new 72-bed hospital, built to replace the old Lord Dufferin Hospital, is now open and in use. The hospital, known as the Dufferin Area Hospital, has been under construction for the past four years.

* * * *

SIMCOE. The newly-expanded and renovated Norfolk General Hospital has been officially opened. The expansion program, which required four years to complete, has increased the

(Concluded on page 56)

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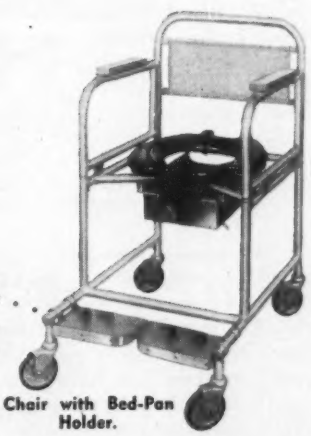

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Provincial Notes

(Concluded from page 54)

hospital's capacity to 100 beds. Included in the program was the erection of a four-storey wing, modernization of services, and renovation of the old building. Improvements include a new heating system, kitchen and cafeteria, central supply room, second operating room, second emergency room, expanded x-ray department, new elevators, and a new conveyor system for taking meals to patients' floors. Cost of the new wing and the modernization program is estimated at $950,000. Citizens of Norfolk county subscribed $175,000, while the remainder came from the federal and provincial governments, town and county councils, and the Atkinson Charitable Foundation.

* * * *

TORONTO. Construction is now well under way on the $600,000 addition to Humber Memorial Hospital at Weston. The new wing will consist of a basement and one storey, with provision for four more storeys to be added vertically in the future. Bed capacity is being increased from 55 to 125 this year. Space is being provided for a larger x-ray department and increased space for emergency services. These extra facilities have been made necessary because of the heavy incidence of trauma cases resulting from industrial and traffic accidents.

Also included in the new section is a 44-bed double corridor maternity division with island nurseries. The obstetrical service section will be operated as a separate unit.

TORONTO. The city board of control has approved an addition to Runnymede Hospital which will provide for a new diagnostic laboratory, x-ray unit, and an elevator. Cost of the addition is estimated at $100,000, of which the hospital has $85,000 on hand. The board has agreed to pay any costs above the $85,000.

* * * *

TORONTO. The Atkinson Charitable Foundation has announced that a grant of $217,000 has been awarded to the Hospital for Sick Children to establish a cleft palate and hare lip research and treatment centre. The money will be allotted over a five-year period.

* * * *

WINDSOR. The new nurses' residence and school, known as the Grace Residence, has been opened at Grace Hospital. Built to accommodate 140 students in either private or semi-private rooms, the new residence was constructed at a cost of over $500,000. One of the features of the building is the lecture hall, which holds 105 students. Pleated, fabric folding doors can close it off into three classroom units. The hall also has a stage which will serve for concerts.

Quebec

COATICOOK. The new 80-bed Ste. Catherine Labouré Hospital was officially dedicated in November. The three-storey building is operated by the Daughters of Charity of St. Vincent de Paul.

* * * *

MONTREAL. It has been announced by officials at the Queen Elizabeth Hospital that the recent campaign for funds has been over subscribed by $3,000. The drive was launched originally to raise $109,500 and a total of $112,419 was received in cash and pledges.

* * * *

MONTREAL. Blueprints are nearly complete for a $2,000,000 expansion program to Notre Dame de l'Esperance Hospital in Ville St. Laurent. New maternity and paediatric facilities will be included in the design, as well as new operating rooms, x-ray equipment, and heating plant.

Newfoundland

ST. JOHN'S. The new 75-bed wing to Grace Hospital, which was opened recently, increases the hospital's capacity to 220. New kitchen and dining room facilities are located in the basement of the wing, with the first floor being used for patient accommodation, the second for maternity cases, and the third for surgical cases. The delivery rooms are situated on the fourth floor and the operating theatres on the fifth floor. The sixth floor contains a patients' solarium. The new wing was built and furnished at a cost of approximately $900,000.

The Importance of Soil

Soil is the basic source of most of our food. All the basic elements, on which our bodies depend for survival, are taken from the soil by plants and converted by them into forms which we can utilize. In this process, the soil itself suffers mineral depletion.

Unless the texture and nutrient value in soil are maintained, it becomes a wasting asset, subject to the law of diminishing returns. The adequate use of correct fertilizers results in lower production costs and also conserves the soil for the future.

Large-scale farming, and the necessity of meeting the needs of a variety of soils, make exclusive use of natural fertilizer impracticable. Commercial mixtures, containing nitrogen, phosphoric acid and potash, separately or in combination, are now in widespread use. In fact, since 1900, consumption has doubled each decade.

In recent years, the "trace elements" have come in for increasing attention. These include iron, boron, manganese, molybdenum, copper and zinc—present in varying small amounts in different soils. These metallic trace elements can be as important to plant growth in their comparatively small quantities as the major elements are in their larger ones but, until recently, it has been difficult to make good any deficiencies of the minor elements in the soil without running the risk of applying an overdose which would be harmful to the crops.

Recently this problem has been overcome by the preparation of a finely-powdered glass containing the trace elements in an almost insoluble form. This product, which is known as fritted trace elements or "F-T-E-", is incorporated in the fertilizer mixture.

The very consistency of a soil can be changed by the soil conditioners, another outgrowth of chemical research. These can change a hard clay soil to a rain-absorbing loam suitable for growing crops and food plants.—*From "C-I-L Oval", Aug., 1954.*

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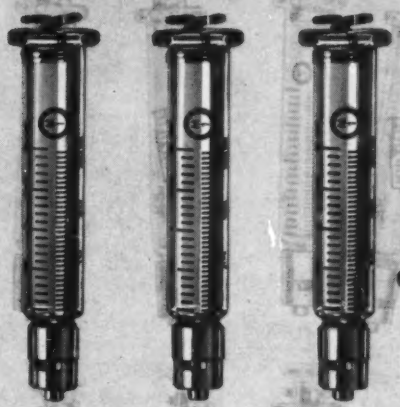

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With the Auxiliaries

Annual Meeting Held by Auxiliary at Winchester, Ont.

Some 111 auxiliary members representing 18 units which make up the Winchester and District Memorial Hospital, Winchester, Ont., attended the annual meeting, held recently. The present membership in the auxiliary stands at 1,170, an increase of 121 over the 1952-53 period. The number of units making up the parent auxiliary, which are spread across a 15- to 20-mile radius, now total over 20. From the treasurer's report, members learned that donations during the past year totalled $4,268.80, about $1,500 more than the previous year. Total receipts for the year were $6,546.90, with expenditures of $3,060, leaving a balance of $3,486.13. This amount is in addition to a fund of $3,600, which was set aside at the end of 1953. It was decided that a further amount of $3,400 be retired against the cost of the nurses' residence, bringing the total allotted for this project to $7,000.

* * * *

Enviable Record Achieved by Auxiliary at Lucky Lake, Sask.

The nine women who make up the auxiliary to the 14-bed Lucky Lake Union Hospital, Lucky Lake, Sask., should be justly proud of their efforts on behalf of their hospital. Expenditures during the past year included: an oxygen tent purchased at a cost of $695; a sterilizer, $1,695; an anaesthetic machine, $925; an electric toaster, fans, tea kettles, clock, and irons; 2 occasional chairs; 2 plastic-covered chairs for the waiting room; linens; towels; sheeting; pillow cases; rubber sheeting; kimonas; pyjamas; wool blankets; $150 for aluminum kitchen utensils; and dishes for the patients and staff. The latest piece of equipment purchased is a new frigidaire. The ladies raise money by holding bake sales, variety shows, sales of novelties, and raffling a late-model car at their New Year's Dance last year. They also hold an annual fruit and vegetable shower, pay weekly visits to the hospital, and send flowers to any of their sick members. A turkey dinner for the patients and staff is supplied at Christmas and cigarettes and chocolates are given to the nurses and doctors.

* * * *

News of B.C. Auxiliaries

At Michel-Natal, the newly organized auxiliary to the Michel Hospital, with well over 100 members, is completing its first year of service with an excellent record. The auxiliary has purchased dressing gowns and slippers for the men's ward, subscribed to two daily newspapers, contributed toward the cost of purchasing a wheel chair and stretcher, and spent $300 for linens, bed-lamps, et cetera. A complete bed-unit will be purchased with the proceeds from the fall fashion show.

Only 16 women make up the auxiliary to the Wrinch Memorial Hospital at Hazelton but they have managed to provide most of the services which other auxiliaries undertake. The women visit patients regularly bringing treats and reading matter and present the first baby born in the hospital in each new year with a silver mug. During the past year they have also purchased curtains, crib-mattresses, two clocks for the operating room and case room, and a centrifuge. Card parties in the nurses' home and a hospital day tea are two functions held to raise money.

The women's auxiliary to the Tofino Hospital have been working hard for the new hospital which was constructed to replace the one destroyed by fire two years ago. The hospital day sale contributed $310 to this worthy cause. An art exhibit was a highlight on this occasion.

At Prince George, the auxiliary found that instead of its usual tea and bazaar, an open house and donation day, at the hospital and nurses' home, was much more successful, with attendance up some 120 over the previous year. During the first half of the year, the auxiliary spent $761 on wall lamps, a wardrobe, four bassinets, 6 armchairs, 20 side chairs, 2 bedside lockers, and a crib.

A new carpet for the nurses' living room and new drapes for all private rooms in the hospital is a project being undertaken by the auxiliary to the Cumberland General Hospital.

* * * *

Carnival Nets Over $2,000

The carnival sponsored by the women's auxiliary to the Carleton Place and District Memorial Hospital was an outstanding success again in 1954. Approximately $2,000 was raised. The carnival is actually a joint community effort with many local organizations being responsible for some of the games and other entertainment.

* * * *

Receives $8,000 from Aid

The Angada Children's Hospital, Kingston, Ont., received a cheque for $8,000 recently from the women's aid to the Kingston General Hospital. The money had been raised by means of a garden party held in June, a tag day, and from receipts from the canteen and gift shop operated by the aid at the Kingston General Hospital. The money will be used to cover the cost of a complete one-bed unit.

* * * *

X-Ray Unit Presented

An x-ray unit, valued at $10,757, has been donated to the All Saints' Hospital, Springhill, N.S., by the women's auxiliary. The Springhill Branch of the Canadian Legion contributed $500 to the auxiliary to help complete payments on the equipment.

* * * *

Auxiliary Aids Bone Bank

A deep freeze unit has been donated to the Saint John General Hospital, Saint John, N.B., by the women's auxiliary to the hospital. The unit will be used to store bones, which are being collected for the bone bank now established at the hospital.

* * * *

Record of Progress for New Mount Sinai Auxiliary

After a little over one year of operation, the women's auxiliary to the New Mount Sinai Hospital, Toronto, Ont., has swelled its membership to over 3,500. The auxiliary has taken as its slogan "EMGAM" meaning "every member get a member". Membership entitles participation in auxiliary activities, including meetings and educational lectures. During the

(Concluded on page 90)

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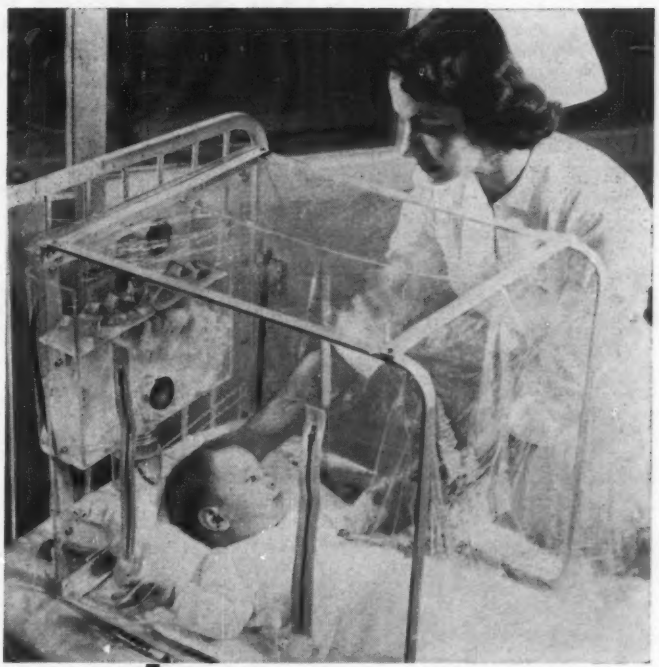

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Book Reviews

INTRODUCTION TO PSYCHIATRIC OCCUPATIONAL THERAPY. By Gail S. Fidler, O.T.R., and Jay W. Fidler, M.D. Pp. 200. Price, $4.00. Published by the Macmillan Company, New York. Available here through the Macmillan Company of Canada Limited, Toronto.

Occupational therapy, as envisioned in this book, has a very real role to play in psychiatric hospitals. Instead of being regarded as nothing but an "Arts and Crafts Department", occupational therapy can be co-ordinated with other more generally acknowledged treatment procedures in the psychiatric field. It can augment psychotherapy or therapeutic efforts, provide opportunities for assisting in a diagnosis and evaluation of personality, as well as to help the patient develop good working habits, and perhaps talent, participate and co-operate in a group, and even provide him with an avocation he may continue either in or out of the hospital.

In showing how occupational therapy can fulfil these goals, the authors are both straightforward and practical. They back up their theories with discussions of very concrete situations. They show how some of the behaviour patterns, usually underlying the development of symptoms, can be managed in an occupational therapy setting to the patients' benefit.

While they stress that this book is an introduction only to psychiatric occupational therapy, the authors have made it an excellent one. It is well worthy of the attention of anyone interested in the development of occupational therapy as it applies to psychiatric care.

* * * *

AMERICAN NURSING—History and Interpretation. By Mary M. Roberts, R.N., editor emeritus of the *American Journal of Nursing*. Pp. 688. Illustrated. Price, $6.00. Published by the Macmillan Company, New York. Available here, through the Macmillan Company of Canada Limited, Toronto, Ont.

As a nurse who has been active in almost all phases of nursing since her graduation in 1899, and as editor of the *American Journal of Nursing* for almost a quarter of a century, Miss Roberts knows well of what she writes. Beginning with the turn of the century, she traces the history of nursing in America up until the year 1952.

In 1900, we learn, the majority of graduate nurses were in private duty practice. Their weekly salary was moving up from the firmly established rate of $15 to $25. They were on duty around the clock, with "a little time off" for sleep and recreation, at the convenience of the family. They wore voluminous, ankle-length uniforms, resplendent with mutton-leg sleeves and usually carried a variety of nursing appliances—packed in capacious, awkward, "telescope" bags. However, whatever the costume, nursing was beginning an exciting period of growth and development, which Miss Roberts shows against a broad and interesting background of events of a national and social significance, as well as medical. We follow nursing through the booming years of expansion of the early 20th century, the great depression, and two major wars, on to the present "atomic age".

Writing with clarity and insight of a period in which she has been a participator, observor, and interpretor, Miss Roberts makes this history valuable and interesting not only to nurses but to anyone who wishes to understand the social changes of the past 50 years.

Booklet on Immunization Revised

A revision of the booklet *Immunization Information for International Travel*, giving the latest facts on immunizations needed by travelers going to every part of the world, has just been released by the Public Health Service of the United States Department of Health, Education, and Welfare.

The booklet contains official information on the immunizations required by each country, as well as the immunizations recommended by the Public Health Service, as precautionary measures for persons traveling abroad. Other items of importance to the traveler include an explanation of the procedure for having vaccinations recorded on the International Certificates of Vaccination form, as well as a list of designated yellow fever vaccination centres and maps showing the areas of the world in which yellow fever is endemic and the yellow fever receptive areas of the United States. The booklet may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, .DC., at 20 cents per copy.

A.H.A. Guide for Teaching Surgical Technical Aides

The American Hospital Association has published a manual to serve as a guide for qualified professional nurses in training selected, non-professional workers in the operating room, delivery room, central service department, or emergency department. The *Surgical Technical Aide Instructor's Manual* outlines a program of instruction for these auxiliary workers, which is divided into classroom and supervised practice sessions. As is pointed out in the foreword, this program should be co-ordinated by one qualified nurse, who, ideally, should devote her full time to the five weeks of instruction. Other staff members are also to be encouraged to participate in the teaching program, especially in the sciences. All subjects must be taught at the level the trainee can understand and are to help her to know the *why* and *what*, as well as the *how* of what she is learning.

The recommendations in this manual represent the thinking of qualified nurses who have had years of experience in operating room administration. It has been prepared for distribution by the Council on Professional Practice of the A.H.A. The price of the manual is $2.00 and it can be obtained from the American Hospital Association, 18 E. Division St., Chicago, Ill.

Judicious Use of Standardization

Nature has made races different in order that they may accommodate themselves to their environment; but other differences, and these are many, are man-made and artificial. It is in the reconciliation of these unnatural differences that international standardization has its greatest opportunity to contribute to improved human welfare, international unity and peace—*Don G. Mitchell.*

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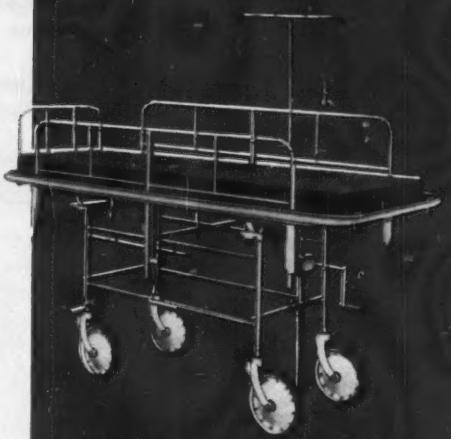

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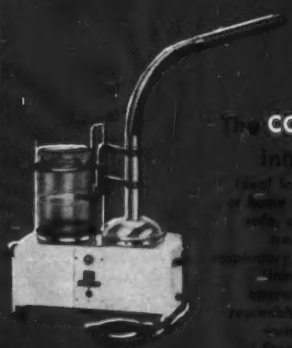

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Here and There

Nursing Education in Africa

In Africa south of the Sahara, nursing education is still largely in the early stages of development and nursing services and training vary considerably from country to country. In 1953 a nursing consultant of the World Health Organization's regional office for Africa made a survey of nursing education facilities and personnel in 15 territories of Equatorial Africa. Her report subsequently served as the basis of discussions at a conference, sponsored by WHO. This conference, held in the autumn of 1953 in Kampala, Uganda, was the first in the region on the subject of nursing. It brought together 33 delegates from 23 countries, to add to the information supplied by the WHO survey and to exchange views on nursing education needs, problems, and plans.

The conference was opened by Lady Andrew Cohen, wife of the Governor of Uganda, who stressed the social aspects of training nurses in Africa: the need for preparing and aiding girls to assume a responsible position in communities in which conditions were far different from those encountered during their training; the difficulties posed by eventual loss to the profession of many girls trained as nurses, and the utilization of their training in their subsequent roles as wives and mothers once they had left the profession; and the problem of raising the status of the nursing profession in Africa. She also called attention to the desirability of emphasizing preventive medicine, of turning emphasis away from the building of hospitals and towards the building up of corps of health visitors and home nurses, and of promoting health education directed towards arousing health-consciousness in the community.

Different philosophies regarding the nursing profession were revealed during the conference, reflecting differences in national policies. The 11 countries of the Belgian, French, and Portuguese powers were represented at the conference solely by doctors, whereas the countries within the British sphere sent only nursing delegates. This seemed to indicate a fundamental difference in approach to nursing education: the former countries apparently consider that physicians should supervise the training and work of nurses; the latter believe that nurses should be trained and supervised largely by qualified members of their own profession. Despite this divergence of opinion—and the consequent variation in ideas concerning the functions and preparation of nurses—there was "a broad base of agreement on goals, though methods of attaining them were often diverse".

The WHO survey had shown that there was a wide range of workers concerned with some or all aspects of nursing in Africa, and considerable differences in educational standards, length of courses, functions, grades, and titles. Both in the survey report and in the conference discussions two distinct trends in development became apparent:

(1) a growth, comparatively recent, of interest in nursing as a career for African girls, paralleling gradual improvements in the general education of girls; and

(2) a more or less general policy of giving a basic nursing course to various categories of male health workers —from first-aid and dresser grades to hospital or medical assistants—who, it was felt, would be an essential part of the health services of many areas for several years to come.

No uniform pattern of education or ready solution for many problems could be suggested by the conference participants. It was stressed, however, that in all training programs instruction in the care of patients must be combined with self-development of the student. Some concern was expressed "lest efforts to place the training of nurses on the highest possible level were aimed at the advancement of the profession rather than at serving the patient" but the answer was that this danger would be obviated by making all training "patient-centred".—*From "Chronicle of The World Health Organization", September, 1954.*

Thailand's Princess Aditya Leader in Health and Welfare Field

A princess from Thailand, Princess Aditya, whose energy and enthusiasm have benefited thousands of underpriveleged children, was the guest of the United Nations International Children's Emergency Fund, at UN headquarters last fall. Princess Aditya has been described as "one of the leaders among the women of the new Asia". In a country where few women take part in public activities, the Princess has been a leader in the health and welfare field for many years. In 1949, she took on the chairmanship of the United Nations Appeal for Children in Thailand. She raised $150,000 in that year and almost the same amount in 1951.

Support for UNICEF has been enthusiastic in Thailand, according to Princess Aditya. That country has given more money than it has received from UNICEF and has pledged contributions for three years in advance, which enables UNICEF to plan long-range projects. Princess Aditya also spoke of the UNICEF-assisted maternal and child welfare centre in Bangkok. The government gave the building and UNICEF equipped it and provided the personnel. All staff are women, including the chief doctor and chief nurse, and the response from mothers has been so overwhelming that attendance had to be limited.

"Social welfare work in Thailand is still rather new", according to the Princess. "In former years, families who could afford to have servants always took care of them and their families—not only housing, clothing, and food, but also sending the children to school. The Princess, who is the widow of Prince Aditya Dibabha, has no children of her own but supports a household of about 30 children and adults, and 18 of her dependents are attending schools and Universities.—*UN Department of Public Information.*

Nursery for Nurses' Children

In an attempt to encourage married women to go back into nursing, a nursery where nurses' children can play and be supervised by a trained member of the hospital staff has been established at The Hallam Hospital, West Bromich, Eng.—*"The Hospital", September, 1954.*

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Notes on Federal Grants

Child and Maternal Health

Two child and maternal health projects in Newfoundland are to receive federal aid. A grant of $12,279 is being made to the Grace Hospital at St. John's to provide modern scientific and technical equipment for the newborn and maternity section. The maternity section is housed in a new wing, also partly financed by federal grants. Another grant of $1,625 will provide for the part-time services of a physician who will investigate problems in child and maternal health in the province. Both projects are aimed at reducing the infant mortality rate in the province which is the third highest in Canada.

Cancer

A federal grant of more than $477,000 to support the cancer detection and treatment services of the Ontario Cancer Treatment and Research Foundation has just been approved. This grant meets half of the cost of the province's 1954-55 cancer program, including the purchase of new cobalt 60 beam therapy apparatus, for clinics in Hamilton, Ottawa, and Windsor, as well as further assistance toward the installation and operation of the cobalt 60 units in London and Fort William. This latest grant brings the total federal aid to more than $1,760,000.

The Foundation maintains clinics in Kingston, Fort William, Hamilton, Ottawa, Windsor, London, and Toronto, and an auxiliary radio-therapy centre in Sarnia. It supports clinical research at all four medical schools in Ontario (London, Toronto, Kingston, and Ottawa), at McMaster University in Hamilton, and in several hospitals and sanatoria in Toronto, London, Kingston, and Hamilton.

In the Foundation's budget the largest single item is for the clinic at Hamilton, which will receive more than $112,000 from the provincial and federal governments. Approximately $78,000 of this is earmarked for cobalt 60 and x-ray therapy equipment. Other substantial items include more than $110,000 for the Ottawa Civic Hospital clinic; $92,000 for the London clinic, and more than $90,000 for Windsor.

Some $9,000 is allotted to the Women's College Hospital, Toronto, for its cancer detection clinic for women, and about $8,000 has been set aside for the University of Toronto as a special grant for training technicians and pathologists in cytological techniques.

Construction

In Ontario, three grants totalling more than $86,000 are being awarded to hospitals in Ottawa, Fergus, and Weston. The Groves Memorial Hospital, Fergus, will receive $70,666 toward the construction of a modern masonry and brick building. The present fifty-year-old structure will be demolished when the new building is completed shortly. The new building will house 34 active treatment beds and two labour beds, as well as 20 beds for chronic patient care and 14 bassinets in cubicles.

The Royal Ottawa Sanatorium will receive a $13,500 grant. It will be used to pay part of the cost of adding 27 beds to the nurses' residence. Previously, the hospital received a $202,500 grant under the national health plan. A $2,500 grant is also being made toward the cost of building a small residence for the nurses at the Humber Memorial Hospital, Weston.

The Hunter Memorial Hospital at Teulon, Man., has been granted $36,393 toward the cost of replacing the present building—no longer considered to be adequate—with a modern, concrete building. In addition to 20 active treatment beds and nine bassinets, the new hospital will contain a community health centre and a 10-bed nurses' residence. Another hospital in Manitoba, the Birtle District Hospital, will receive a $26,313 grant. The funds will help meet the cost of replacing the present hospital building which is now considered obsolete. The new building will house 16 active treatment beds, a six-bassinet nursery, operating and delivery rooms, x-ray and laboratory facilities, a community health centre, and an eight-bed nurses' residence.

A grant of $4,416 has been made to the Uranium City Hospital, Uranium City, Sask. The new hospital will contain four beds, operating and examining rooms, and space for a community health centre.

A grant of $30,000 has been made to the Prince County Hospital at Summerside, P.E.I. The money will be used in the hospital's current building program. A new masonry and brick nurses' residence is being built on a lot adjacent to the hospital. It will provide accommodation for 54 nurses. The existing accommodation for the superintendent of nurses, together with part of the board room, will be used to accommodate three additional active treatment beds.

The Woodstock General Hospital in Woodstock, Ont., will receive a grant of $84,000 to aid a current expansion program, aimed at providing an additional 73 beds and 33 bassinets.

Professional Training

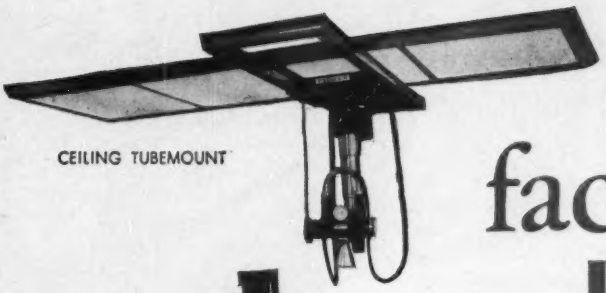
Saskatchewan will receive assistance in giving short-term training in occupational radiation protection. The amount of the federal grant is $584.

The Toronto General Hospital, Toronto, Ont., will receive a grant of $2,333 to provide for the part-time services of a registered psychiatrist on the medical wards. The psychiatrist will be concerned not only with patients admitted for psychiatric treatment but also with those requiring psychiatric treatment in association with other forms of medical care. Development of this service is on an experimental basis.

Public Health

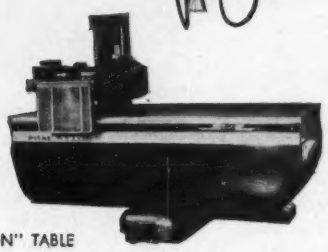
Newfoundland is to receive a grant of $7,896 which will be used to provide equipment for the treatment of poliomyelitis at the St. John's General Hospital. Many complicated cases from all parts of Newfoundland are treated at this hospital.

Health services in Saskatchewan are to benefit from two more federal grants. At the Regina General Hospital in Regina, six beds for chronic poliomyelitis cases are being added to the isolation wing. Aiding this project is a federal grant of $10,500. A nutrition institute will be held in Regina, with the help of a grant of over $700.



CEILING TUBEMOUNT

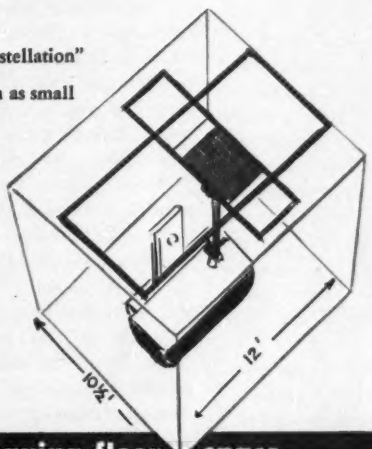
facts·figures



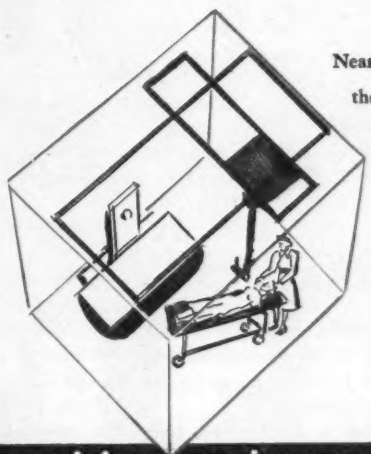
"CONSTELLATION" TABLE

show how much you gain by using this "island" table and free-ranging x-ray tube

You can put a "Constellation" anywhere in a room as small as this because it's not bound to the Ceiling Tubemount

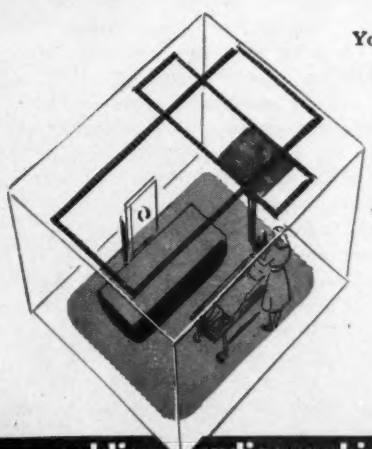


in saving floor space



Nearly three-fourths of the floor will remain clear (99½ out of 126 sq. ft.) for carts, workteams or observers

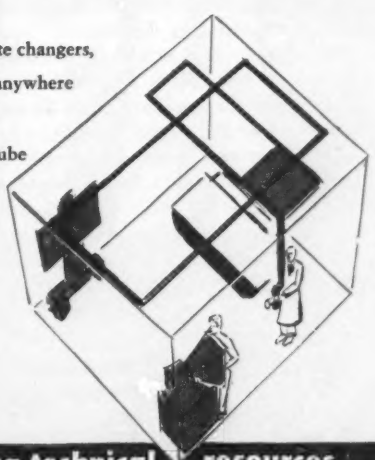
gaining work space



You can move the x-ray tube all over the gray-tinted area for radiography on the table or anywhere within the 63½ sq. ft. surrounding it

adding radiographic coverage

You can put cassette changers, Bucky stands, etc. anywhere around the room because the x-ray tube comes within 18" of any wall.



multiplying technical resources

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Synthetic Narcotics—Back Door Burglar

MOST people are familar with one version or another of the story of the house-holder who carefully locks and bolts his front door before setting out on a journey but returns to find his domain has been burgled just the same because thieves managed to make their way in by the relatively unguarded back entrance. Such, in effect, is the situation which confronts the world today as it seeks ways to control narcotic drugs.

The "front door" had a lock placed upon it in 1931, when the Geneva Convention for limiting the manufacture of narcotic drugs and regulating their distribution was concluded under the auspices of the League of Nations. Since then, however, a new and alarming menace has entered the world's back door in the shape of synthetic narcotics, made from raw materials such as the by-products of coal tar and petroleum, which are not themselves narcotics and which, therefore, cannot be controlled in the same way as the natural substances. To place this back-door burglar under lock and key is now one of the main problems confronting the United Nations in its work in the narcotics field.

The difficulties in placing these synthetic drugs under international control are manifold. The crux of the matter is how to prevent dangerous addiction-producing synthetics from coming onto the market without controls even before it is definitely established that they are harmful. As one United Nations' expert puts it: "All natural narcotic drugs are considered guilty until they are found innocent. Synthetics, on the other hand, have to be found guilty before they are pronounced guilty. The reason for this is that one cannot yet define, in advance, all the groups of drugs which are suspicious".

An important consideration is the question of how to place synthetics under "provisional" control without harming industry, or medical research, in the process. Another difficulty would be the expense and complication of obtaining a prescription and observing other narcotics regulations every time someone wished to use a "suspect" drug for some legitimate purpose. Yet a further difficulty is the fact that it might be much easier to establish illicit factories for synthetic drugs than for "natural" ones. Since the raw materials for natural drugs are under international control, they must be illegally procured, either by import or other methods. And the procurer is subject to severe penalties. However, with synthetic drugs, it is comparatively easy. For example, you can buy coal tar without difficulty.

What is being done on the international level to solve this complex problem? The matter has been before the United Nations Narcotic Drugs Commission since its first session, in 1947. As a result of its studies, the Commission recommended as a provisional solution the conclusion of a new international agreement which would provide machinery under which new synthetic narcotics could be placed under the same international control as natural ones. The recommendation was carried out and, during its Paris session in 1948, the General Assembly approved an instrument which subsequently became known as the Paris Protocol.

The Protocol obligates its parties to inform the UN Secretary-General of the appearance of any drug which is outside the scope of the 1931 Convention and which the country in question thinks may be abused and may produce harmful effects. The Secretary-General must then pass on the information to the other parties to the Protocol, to the UN Narcotic Drugs Commission and to the World Health Organization. The next step lies with WHO, in deciding whether the drug is addiction-forming or if it can be converted into an addiction-forming product. If the decision is an affirmative one, the parties to the Protocol are bound to subject the drug to the appropriate controls.

Another very important section of the Protocol provides that the Narcotic Drugs Commission may decide whether or not the drug should be placed under provisional control pending the announcement of WHO's decision.

During the six years following the enactment of the Protocol, the Commission and its parent body, the UN Economic and Social Council, have kept the problem of synthetics and their provisional control under continuous scrutiny. Under a Council resolution adopted in 1953, sustained efforts have been made by both WHO and the UN Secretariat to collect all available information on various medical and scientific aspects of the drugs, including such points as the extent to which synthetic analgesics and synthetic opium alkaloids, in particular, are likely to replace "natural" narcotics in the future.

Generally, the studies are being made in two directions: (1) to establish the relationship between the chemical structure of a drug and its addiction-producing qualities, *i.e.*, to discover what it is in the drug's formula which actually produces addiction; and (2) to discover whether there is any relationship between drugs with strongly analgesic properties and addiction-producing drugs. If either of these two points could be established, the "suspect" groups could then be placed under provisional control.

At its session last spring, the commission decided that measures to prohibit or limit the production of synthetics must not impede research aimed at the discovery of new drugs. Research of this kind, the members emphasized in their report, was "indispensable to the ultimate goal of discovering strong analgesics without addiction-producing properties". — *Department of Public Information, United Nations, N.Y.*

Hospital Food Service Manual

A reference book, designed especially to answer general as well as particular questions concerning hospital food service, has been published by the American Hospital Association and the American Dietetic Association. This *Hospital Food Service Manual* is the product of five years of study and has been planned so that it can be adapted to large and small hospitals. Throughout, the stress is placed on the importance of food to the well-being of the patient. There is much valuable information on a variety of pertinent problems—how to plan a dietetic department, purchase, store, and prepare food, the care and cleaning of equipment, personnel training, and so on.

The price of *Hospital Food Service Manual* is $6.00 and it is available through the American Hospital Association, 18 E. Division St., Chicago, Ill.

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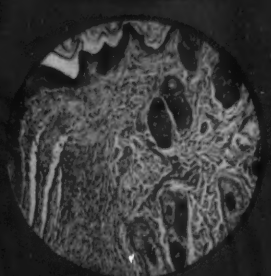
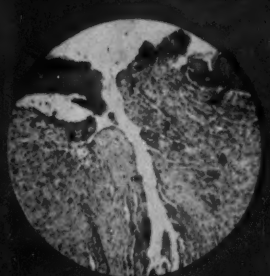


Skin section of rabbit, 14 days. Note: (1) deep wound is healed, (2) new skin entirely closes wound.

PETROLATUM GAUZE



Section from similar wound in rabbit, 14 days. Healing is incomplete. Skin growth retarded.

Dressing in Surgical History that Keeps Wounds Dry without Sticking!

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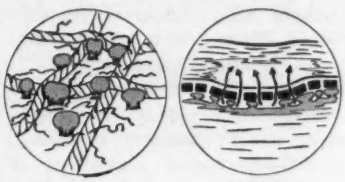
This is the newest advance in hospital dressings. This is TELFA.

WHAT IT IS: TELFA is an entirely *new type* of dressing for all wounds. It consists of a nonwettable, perforated plastic film firmly bonded to a highly absorbent nonwoven material (WEBRIL®) of 100% pure cotton.



Gauze TELFA

HOW IT WORKS: Wound drainage is absorbed *through* perforations in plastic film (placed next to wound) by the virtual pumping action of highly capillary absorbent cotton backing. Perforations are large enough to allow full absorption, small enough to exclude tissue buds . . specially designed to prevent reverse flow of drainage.

WHY IT'S BETTER THAN ALL-GAUZE: Gauze fibers become anchored in clotting exudate. Buds of regenerating tissue grow into the dressing. When removed, dressing ruptures tissue buds, which causes fresh bleeding and delays healing.

TELFA plastic facing is nonwettable and fiber-free. Removal doesn't damage tissue buds, doesn't delay healing.

WHY IT'S BETTER THAN PETROLATUM GAUZE: Petrolatum gauze very often sticks. Because it is nonabsorbent, it fails to keep wounds dry. Unabsorbed drainage produces maceration and delays healing.

A TELFA dressing does not stick, yet maintains full absorbency. Highly capillary cotton backing sucks drainage away from wound area . . . plastic film *keeps* it away, preventing maceration.

GOES ON "UPSIDE DOWN"

HERE'S THE SECRET of TELFA effectiveness—the nonwettable perforated film goes *next to the wound*, separating the absorbent material from clotting exudate and granulating tissue buds. A TELFA dressing thus absorbs without sticking, permits undisturbed healing.

CLINICAL RECORD: Initial clinical studies covered 918 cases of all types of wounds, both major and minor. Ideal results were reported in over 99% of cases. In only 8 cases were results short of ideal . . . cases involving thick, purulent secretions where there was some sticking and incomplete absorption. Even here, TELFA was considered as good or better than conventional dressings. Subsequently, TELFA has been used successfully on thousands of patients of all types.

ECONOMICAL, TOO: TELFA nonadherent dressings actually *cost much less* for patient care.

HOW SUPPLIED: 2½" x 4" and 3" x 8" strips, in hospital cases. 2" x 3" sterilized envelopes for doctors.

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Setting up a Disease Index

(Continued from page 46)

consent to its use for teaching purposes. This card gives the identification of the patient—name, age, ward, hospital number—as well as the diagnosis, area to be photographed, and the type of print desired. Later when the film is developed, a number is assigned and this is then added. It is from this information that the condition is coded for the disease index and, therefore, the more specific the information obtained the more accurate the coding will be.

The Numerical Index

The numerical index is primarily a reference for the photographer but it is also the means of identifying the individual slides. On the card (see Figure III), there is space for details of lighting and exposure as well as the patient's identity and the diagnosis. In some hospitals, it may be of use to have a print of the film on this card, especially if the slide file is at some distance from the index. However, at the Winnipeg General, this is neither practical nor necessary.

In setting up the disease index, it was sought to make it as uncomplicated as possible and yet strictly in accordance with the standard nomenlature. We count on the co-operation of those making out the requisitions to diagnose according to SNDO, for only then can we hope to make an accurate index. If in doubt, the photographer checks his coding with the physician when he comes to see the pictures. For an example of a disease index card, see Figure IV.

Broad topographical groupings were used, as given by Mrs. Adaline C. Hayden, writing in the June, 1954 issue of *Hospital Management*, as the basis of topographic codes, with the usual medical terminology rather than code. We have made a copy of this list for the active reference of the person filling in the disease index cards, thus making the groupings consistent in those conditions where it is practical to use a group code.

In coding tumours, we felt it would be best to make a disease card for the tumours of each specific organ, as listed in standard nomenclature, and to put the ones not listed for that organ under—899 (if malignace is indicated) and under—8Y0 (if benign or unspecified). Further details of etiology may be placed in the column for "special features".

Filing in the Disease Index

The Winnipeg General Hospital is a teaching hospital and as most of the requests for illustrations are to demonstrate a disease condition, the photographer wished to have each specific disease filed separately. For this reason, we decided to reverse the usual filing system and to have the main divisions according to etiology while the sub-divisions are according to systems. Thus, for example, all tumours are to be found in one large etiological section (800), with subdivisions according to the systems; while all infections are found in the etiological division —100, with its subdivisions according to systems. For example, if there were a request for an illustration of *epidermoid carcinoma* of the lip, one would first look up the code number in standard nomenclature: 611—814. Then, in the disease index, one would look for the main etiological division—880 and, under the topographical sub-division 600—one would find the card headed 611—814: epidermoid carcinoma of the lip.

Though this may appear a little confusing for those who are used to having the main divisions according to systems with etiology in the subdivisions, this method is more satisfactory for the clinical photographer.

We have found it necessary to make a miscellaneous section for special photographs of procedures, operations, and non-pathological conditions, et cetera, which are used for teaching purposes.

Summary

With these four files, we believe that it will be possible to answer all requests with the utmost efficiency. Thus, if only the name is available in a request, the slide number could be located through the alphabetical index or the day book. If we are given the slide with no data regarding it, we should be able to locate the information through the numerical index and, if necessary, refer from it to the alphabetical index. Depending upon the type of slide, it may be feasible to put a limited amount of information on the slide itself. Then again, if a doctor wished to know if a picture had been taken of a certain patient, the day book would be the best source of information. Finally, if a specific disease condition was wanted for teaching purposes, then, by finding the code number in standard nomenclature, the photographer could readily find the disease index card

(Concluded on page 82)

Figure IV

Slide No.	Date	Patient's Name	Doctor	Spec. Site	Spec. Feature	Colour	Size
P646a-d	6/54	Black, John	White		Before and after treatment	K	3mm

Figure III

File No. ..... Date .....

The Winnipeg General Hospital

Name .....

Case Particulars .....

Photo Data ..... Colour .....

Lights .....

Aperture .....

Shutter .....

Meter Reading .....

Other Remarks: .....

Drs. Case .....

Layout Plan

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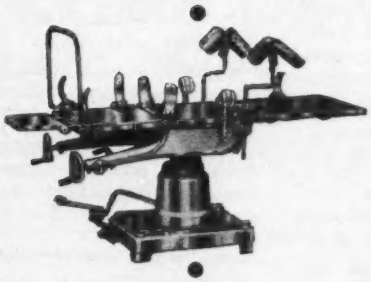

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I became a student again

(Concluded from page 45)

tell if the linen is clean by its colour, feel, and odour; but there is much more to know than that. When a laundry supervisor talks of bleaches, sours, temperatures, builders, washing cycles, and rinses—would you know why every process is carried out? I believe that every hospital administrator should. Again, this information can be obtained in the necessary capsule form, from a course of study such as the extension course.

What about the laboratory? How would you know if the laboratory technician was doing her job in the manner it should be done? Well, you might say, if she were not, the doctors would soon complain. How do you know that the volume of work might be such that she cannot spend the necessary amount of time on each procedure? You can find out by learning something about her duties. It is not necessary to know the actual methods of carrying out various procedures but through observation you can get an idea of the length of time necessary for each procedure or test and then compare that with the average time recommended. Such a comparison was very enlightening to me. The new unit system we now use is ideal.

Human Relations

One section of the course I especially enjoyed, and reaped much benefit from, was the lesson on human relations. I learned that an administrator must concern himself with the viewpoints, feelings, and thoughts of employees. Vital material on this subject was given to us quite early in the course and, at the first summer session held in Regina, we were most fortunate in having on the faculty a lecturer who was able to teach us much about human relations in dealing or bargaining with a union. Although we do not have a union at our hospital, the lectures made me think more about employees and realize that before any change in duties should be made, those most concerned should be consulted and advised.

To have happy, contented employees, is the ideal situation in the hospital when you consider that they are constantly in contact with persons who are ill. A happy person cannot fail to pass on some of his happiness to the patients.

Another phase of the subject with which we dealt at some length was relations with the medical staff. Since practising physicians are not employees, they are not subject to the same rules as the rest of the personnel. They must have their own by-laws, regulations, et cetera, so that they can govern themselves. Once they are organized, the administrator can bring their own rules to the attention of the medical staff, in cases of infractions.

The written lesson material on relations with the medical staff was excellent but still left many questions unanswered. The summer sessions provided answers and solutions. As a result, I was able to show our medical staff how they should organize and pass their own by-laws and regulations. Although much has been accomplished, we still have difficulty in achieving regular monthly meetings to discuss the clinical work of the hospital.

Since the board is responsible for the quality of medical service provided in the hospital, the administrator must be able to advise the board in this regard. As the doctors are the only persons competent to judge abilities of their confreres, the quality of medical care can be assessed only through their own committees. Our doctors have consulted me on the proper method of setting out in print the wishes of the staff. As a result, I have acted as secretary to the medical staff and all its committees. This I found to be advantageous as I had first-hand knowledge of their deliberations. I was also in an ideal position to bring to their attention the wishes and suggestions of those responsible for management of the hospital. All in all, I am convinced that my study of hospital administration through the extension course has earned for me increased respect among the medical doctors.

Other lessons in the course which I found particularly beneficial were those relating to building maintenance and design. Knowledge obtained through the written material and lectures at the summer sessions helped us to improve our functional services in the existing building.

Fostering Desire To Study

With no intention of frightening anyone who may contemplate applying for the course, I might say that the amount of literature which we were required to read was enormous. As I mentioned earlier, I noticed this particularly as it had been a number of years since I had graduated from high school and I had lost the art of reading and quickly grasping what an author is trying to put across. Many an hour I spent, with furrowed brow, until at last I had what I thought was the gist of an article. This effort, I might say, had other advantages as well. I developed a desire to read again which remains with me as I constantly obtain new ideas from the various hospital journals. This desire for further study and knowledge is, in my opinion, the greatest benefit derived from the extension course.

A phase of the second summer session, which I found most valuable, was the discussion period. After preparing a paper on some hospital subject, each student would present it to a group and then lead the discussion for the balance of the period. By the time we had taken part in a number of these sessions, we had gained considerable knowledge of the administration problems which the speaker had met and resolved. Asking questions and taking part in the discussions was beneficial as, again, this method stimulated our thinking along the lines of hospital administration. The experience of delivering a paper on a topic assisted in training us to express our opinions.

Never a day passes, even after a year, that I am not able to apply the principles expounded and taught in the extension course. The knowledge that you have available, at your finger tips, the material prepared by the most experienced lecturers and authors is very reassuring. Seldom is a problem so urgent that you cannot take the time to see what solution was offered by eminent writers of hospital literature. Adaptions must necessarily follow to fit your personal problem but you can feel confident that your problem is not entirely new and many answers are available for the seeking mind.

Grant for B.C. Cancer Foundation

The British Columbia Cancer Foundation moved a step closer to the completion of a $250,000 addition to its institute, when a cheque for $145,000 was presented to the Foundation by the British Columbia division of the Canadian Cancer Society. Another $15,000 will be forthcoming from the Society in the near future. The grant will be used toward the cost of building a 36-bed home for patients undergoing treatment at the institute.

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Patient Education Plan at Manitoba Sanatorium, Ninette

(Excerpts from an article which appeared in the "Bulletin" of the Canadian Tuberculosis Association, June-July, 1954.)

DOCTORS and nurses who have worked in sanatoria for years are often heard expressing regret that "there isn't time to talk to the patients the way we did years ago". This is commonly attributed to the nursing shortage. Dr. Paine, medical superintendent of the Manitoba Sanatorium, Ninette, Man., thinks that though the shortage is an important factor it is not the whole story. New techniques and new methods tend to shorten the time doctors and nurses spend with the patient. This has distinct advantages in stretching a small staff over a great deal of work but there is an educational loss, lamented in many quarters.

At Ninette, where Dr. David Stewart's faith in education is still a live gospel, they are not willing to accept the loss of teaching opportunity and, to compensate for reduced time the nurse can give each individual in the ward, they have instituted classes for the patients, conducted by Miss Edwina Buchan who, in addition to considerable experience in nursing tuberculosis, has public health training.

The "course" consists of six lectures which are spread over a six-week period. Patients who are on one wash-up exercise attend the lectures. Lectures start with instruction about the germ, which patients are shown under the microscope. They also see what a pair of lungs look like and what tubercle bacilli do to them. The part played by rest in and after recovery is introduced often and from as many angles as possible.

How the germ gets around and how to stop it getting around, receive a good bit of attention with plenty of emphasis on practical ways and means of controlling spread. Miss Buchan reports that this is one of the topics which can be calculated to start patients asking questions. Patients are encouraged to ask questions but feel shy about it at first. Discussing how they might have contracted the disease usually starts somebody talking. After that the tone changes from sraight lecture to seminar.

Visual aids are used such as slides, which are shown through the microscope, sketches prepared by some staff member, samples of wax packs, pictures from medical books or diagrams culled from advertising material or films on tuberculosis. Scientific terms are introduced into the lectures only when necessary and an informal conversational tone pervades not only the classes but any mimeographed material given out to patients.

Of course the classes do not mean that patients do not have the opportunity to talk to the doctors and nurses. In the classes the basic points are covered with every patient. Thus when doctors and nurses are asked questions by the patients they do not have to start at the beginning and fill in the background but can come right to the point.

In addition, to the class instruction and day-to-day conversation with doctors and nurses, all patients have conferences with the doctors, one on admission and one before discharge and periodically in between. Patients who are having surgery often have several conferences with the medical staff.

Ninette has a good many Indian patients who speak neither English nor French. Although there is a large language barrier they seem to be interested and are very attentive.

Miss Buchan also instructs the nurse affiliates, ward aides, and orderlies. The popularity of the instruction can be judged by the fact that the laundry staff has requested that they attend classes.

One advantage of the patients' classes as a means of instructing those on cure is that in some places it might be a way in which nurses not available for regular duty could be employed. Every sizable community has a good many nurses among the married women who, though their home duties rule out employment on the wards, might be able to muster time for a patients' class or two a week. Even with a house to look after, a good many married nurses could spare time in the middle of the day, though they cannot be away at meal time or in the evenings.

It is the considered opinion of the Ninette staff that education ranks high as a means of keeping patients from leaving against medical advice.

C.H.A. Extension Courses —

APPLY NOW FOR 1955

Applications are now being received for extension course classes in hospital organization and management and for training medical record librarians, which commence in September, 1955. Those interested are advised to apply early. Only one class is enrolled each year and there are quota restrictions. Other things being equal, priority of acceptance will be based upon the dates applications are received.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

National Health Week

Canada's 11th National Health Week will be held from January 30th through February 5th. The week is sponsored by the Health League of Canada, in co-operation with government departments of public health. Special promotional and educational programs are being prepared for that week.

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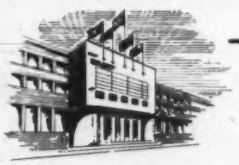

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- **An important address by Georges Léveillé, Quebec City, President, Canadian Tourist Association**
- **More than 150 exhibits of new supplies and equipment**

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Administrator and Trustee

(Concluded from page 36)

tive administration". With this understanding and with the board, as well as the superintendent, trying to protect the other's privileges, the two features of administration can flow smoothly, one to the other. Confidence and team work are desirable features that can be attained when a strong board and a capable superintendent work together under a good relationship policy. Speaking very generally, policy is concerned with all features above the departmental level. To sum up, the best relationship between trustee and superintendent is achieved when neither one nor the other attempts the dual responsibility of administration and where each respects the other's obligations.

W: The administrator's day is a full one. Can the trustees help him make every minute count?

A: Yes, time can be saved or wasted at a meeting. An orderly approach towards a decision is helpful. It is also a good idea for the board chairman and the administrator to arrange a mutually convenient time to meet each week. Each should respect the time obligations of the other.

W: What about the courage necessary to face up to decisions?

A: An important responsibility of a trustee is the making of sound decisions. Many of his other qualities centre upon the approach to and finalizing of decisions. Judgment unduly prolonged is demoralizing, as well as the "off-the-cuff" decision which sometimes has to be reversed. Any situation should be fully explored and action taken in accordance with the facts of the case.

W: What about the trustee who listens to everyone who has some personal axe to grind?

A: That type of trustee can be embarrassing to the administrator. The administrator would look for the kind of trustee who could say to the complainer: "I will be glad to arrange a meeting between yourself, myself, and the administrator to talk this over."

W: In suming up your remarks, we could say that you believe that the objectives of good hospital administration should always be considered when a trustee is being sought. Methods must be devised whereby trustees are obtained who will contribute to the attainment of these objectives. General qualities of character and experience are more essential than specialists' qualifications. You talk of initiative, progressiveness, a determination to reach high objective standards, respect, loyalty, courage, and proper procedure in making decisions. You certainly are asking for pretty high standards.

A: Yes, we do require high standards in the hospital field. There is nothing more important than the health of our people.

Courses for Medical Record Librarians—a word of explanation

It has come to our attention that there still arises in the minds of readers some confusion concerning the two methods of training available to medical record librarians in Canada. We shall try to clarify.

Formal academic one-year courses have long been provided by certain hospital schools. Those now established are:

Halifax Infirmary, Halifax, N.S.
Hotel Dieu, Montreal, P.Q.
Hotel Dieu, Kingston, Ont.
St. Michael's Hospital, Toronto, Ont.
Winnipeg General Hospital, Winnipeg, Man.
Edmonton General Hospital, Edmonton, Alta.

It is also anticipated that a school will open at the Royal Columbian Hospital, New Westminster, B.C., in the fall of this year.

Students are accepted into these schools who meet the required educational standards—senior matriculation (or equivalent), nurse registration, or normal school certificate. On the completion of the course, they are then eligible to write the Registration examination of the Canadian Association of Medical Record Librarians.

The other type of training available in Canada is the two-year extension course, sponsored by the Canadian Hospital Association, in co-operation with the Canadian Association of Medical Record Librarians. This course is offered to *personnel employed in medical record departments of hospitals or similar institutions* who cannot, for one reason or another, undertake formal training. Students who wish to apply for this course do not need to have as high an educational standing as that required for entrance to the hospital schools. The two-year extension course consists of 32 lessons, with two intra-mural sessions, each consisting of four weeks of practical experience in a hospital medical record department, under the guidance of a registered medical record librarian. Upon completion of the first part of the course, 16 lessons and an intramural session, students receive first-year certificates. Upon successful completion of the second year, they are entitled to a certificate of achievement, signifying that they have taken the entire, two-year extension course. This, alone, does *not* qualify the students to write the Registration examination of the Canadian Association of Medical Record Librarians, *unless* they meet the educational requirements and have the practical experience which the C.A.M.R.L. deems necessary.

Therefore, the extension course is not intended as a substitute for those who are able to attend a hospital school. It is for those who are employed in a medical record department, desiring training in this work, but who are unable to attend a school.

Applications for the extension course for training medical record librarians are accepted until March 31st, 1955. For information, see page 74.

—*D.McP.* ●

Holiday in Italy

The United Rome Hospitals are endeavouring to launch an exchange project, whereby doctors from several European countries are to be given an opportunity to spend a few weeks in Rome free of charge, providing arrangements can be made for doctors from the Rome hospitals to spend a similar period in the countries participating in the scheme. Hospitals in France, Germany, Great Britain, and Switzerland are being approached in the first instance. The Rome hospitals offer free board and lodging to foreign doctors whose hospitals are prepared to extend similar hospitality to hospital doctors from Rome. It is suggested that the visits might last from two to four weeks and that this period could be used by the visiting doctors to study hospital practice in the town where the host hospital is situated. Doctors who wish to take advantage of the opportunity are invited to communicate with the honorary secretary and treasurer of the International Hospital Federation, Capt. J. E. Stone, 10 Old Jewry, London, E.C.2, England.—*"News Bulletin", International Hospital Federation, Sept., 1954.*

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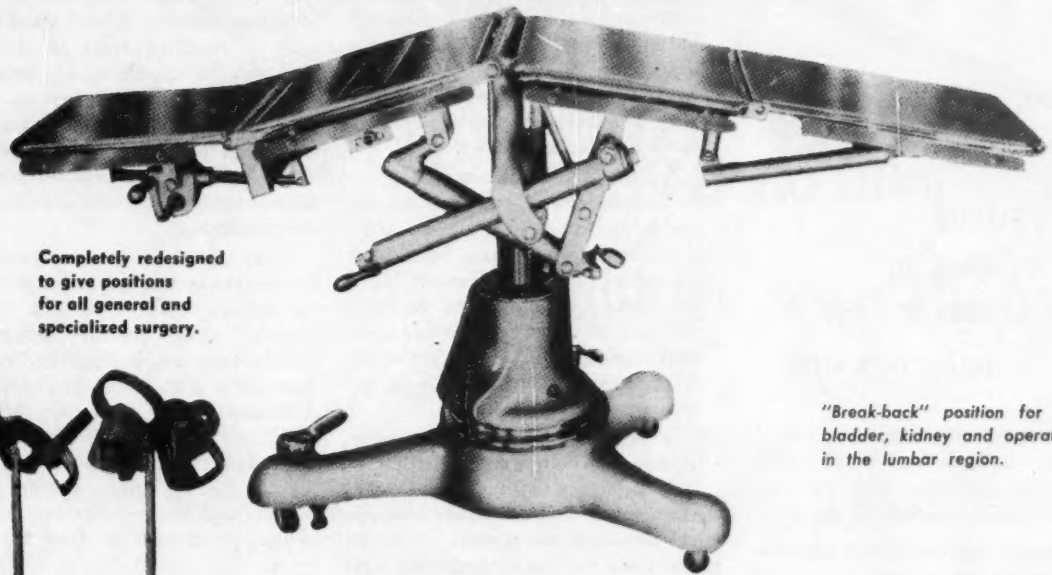

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Hope for the Feeble-Minded

The mentally retarded person has been venerated in some primitive societies and burned at the stake in others. He has been celebrated in history, story and play as the "village half-wit", made the target of jokes, hidden away in back rooms, or locked up in institutions.

These attitudes have arisen very largely from ignorance of the nature of mental backwardness. Now, however, the condition is recognized as a disease and not as a hopeless and often shameful blight. The trouble is not governed by heredity as much as it was once believed. This gives the encouraging possibility that prevention can play a big role in its elimination.

The terms "mental retardation" or "feeble-mindedness" are commonly used in connection with a wide variety of conditions whose main feature is a sub-normal level of intelligence. Major preventible causes can now be listed with a good deal of assurance—pre-natal environment, birth abnormalities, infection, chemical poisoning, and nutritional deficiencies.

In regard to pre-natal environment, German measles is a significant factor. In 1943, a group of Australian doctors found that a number of mothers who had developed the disease during the first three months of pregnancy gave birth to children suffering from brain abnormalities and eye cataracts. This finding was subsequently confirmed in many other parts of the world.

Other studies have disclosed a connection between mental retardation and a substance in the blood stream of the mother which is incompatible with the blood of the unborn child. Some researchers have found that repeated x-ray or radium treatments during certain periods of pregnancy may bring about damage to the unborn baby's brain.

There are some dangerous fallacies about pre-natal environment, such as that marriage of first cousins produces mentally defective children. This is certainly not confirmed by the studies of the Levinson Foundation for the Mentally Retarded, in Chicago, Ill. While an occasional case of feeble-mindedness can be found in such offspring, people of unusual talent and intelligence are often born from these marriages.

Another common misconception which has been exploded is that mentally defective children are born largely to parents over forty. In a group of 65 patients, the average age of the mother was found to be 30 and of the father, 31.

Mental defectiveness may arise when there is an insufficient amount of oxygen during, or immediately after, birth. This is often found to lead to damage to the brain cells.

Hormones, the body's chemical regulators, may also play an important role. Insufficient secretion of the hormone-producing thyroid gland may cause a newborn child to develop cretinism, a condition of arrested physical and mental development. Impaired function of the pituitary gland is believed to have a close relationship to mongolism, a disorder marked by extreme mental deficiency and physical abnormalities.

Some infectious diseases involving the nervous system may leave permanent damage to the brain and, consequently, cause mental deficiency. Among these are encephalitis, an inflammation of the brain, meningitis, an inflammation of brain membranes, and some types of syphilis. Fortunately, modern antibiotics have proved highly effective in combating these diseases and in checking them before permanent damage is done to vital organs.

With these causes now known, much of the mental backwardness that might have occurred in the future can be prevented. But what of the feeble-minded child who already with us?

One of the most promising approaches is an operation which increases the flow of blood and oxygen to the brain. The two doctors who developed the technique report that about 35 per cent of the first 125 mentally retarded children on whom it was performed have shown improvement. The results were particularly gratifying in patients who had also been suffering from convulsive seizures.

Surprising results have been achieved in the field of nutrition. In one clinic, for instance, a "build-up" diet using iron and multiple vitamins, including Vitamin B_{12} have produced marked improvements.

Although no specific treatment has been discovered to cure every case of mental retardation, there are many who can be helped to a surprising degree. Something constructive can be done for every patient.—*SIS:Medical Features.*


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Standard of Excellence

(Concluded from page 34)

result of these examinations should be reported in duplicate with a copy to the patient's file and one to the hospital laboratory.

The remaining two essential divisions—nursing and dietary—are often the services by which the public judge a hospital. It is important that these services be good at all times but, no matter how perfect they may be, they cannot, in this day of enlightenment, conceal any deficiencies in the standard of treament.

The complementary and service divisions presuppose a breakdown of the treatment services into departments. Even in institutions of from 25 to 50 beds, departmentalization can be undertaken for the major specialties such as medicine, surgery, and obstetrics, with a regularly appointed head of each department. Your staff organization must provide that the privileges of each staff member be clearly defined so that only those qualified for work in a specific service will be assigned to that department.

Do not try to over-departmentalize. A small hospital should be organized, when possible, into the three major services, surgery including gynaecology, medicine, and obstetrics. The Joint Commission expects that a large teaching hospital will have many of the specialties organized into departments but fully realizes that a small institution has not the facilities nor qualified staff for such extensive departmentalization.

Approximately only 40 per cent of hospitals in Canada of 25 beds and over have availed themselves of the advantages of the accreditation program. The Canadian Commission with the Joint Commission and their representatives are most desirous to give all the assistance possible to any hospital. If, in their oppinion, a hospital has not met the minimum requirements, there will be no criticism but an honest effort to help it to correct the deficiencies and together work for better patient care.

Accreditation calls for co-operative effort on the part of every member of the hospital staff. It should be the ambition of every hospital board, every administrator, and of all physicians and surgeons associated with a hospital to have their hospital fully approved. Accreditation is the *hall mark* of good administration and of good patient care. It is a contribution to progressive medicine.

Shriners Aid Niagara Hospitals

Contributions amounting to $11,500 have been made to five hospitals in the Niagara area by the Niagara Peninsula Shrine Club. The Greater Niagara General Hospital received almost half of this amount, $5,500. The money will be used to equip a room in the new hospital for the treatment of cerebral palsy cases. At St. Catharines, the General Hospital received $1,000 to complete equipping a similar room. Other hospitals receiving donations are: Port Colbourne, $2,000; Douglas Memorial, Fort Erie, $500; and Dunnville Hospital, $500. The Shriners Hospital for Crippled Children in Montreal also received $2,000. Funds were raised by the circus and other activities of the club during the past few months.

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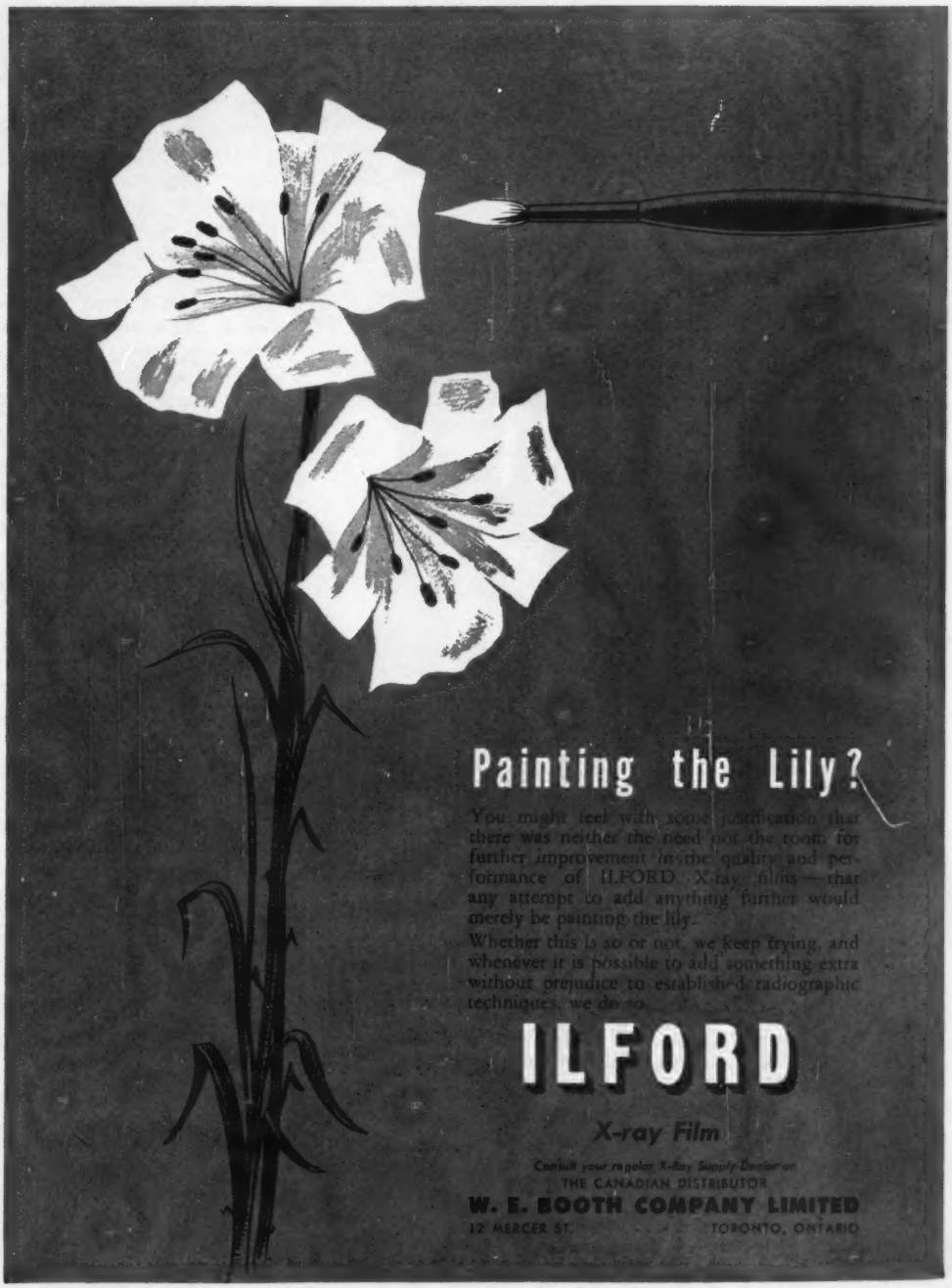
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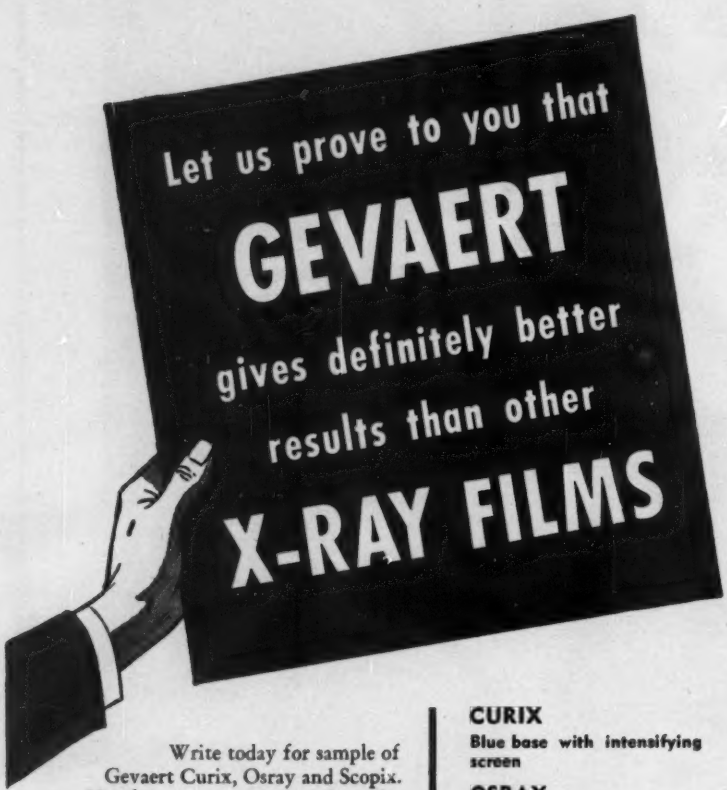
Setting up a Disease Index

(Concluded from page 70)

for that condition in the disease index. This card will give full information regarding all slides and prints available.

In setting up this system we have had problems which are no doubt peculiar to our situation. One of these has been to incorporate all our old slides into the new system. This has meant coding conditions which were often incompletely diagnosed, as well as renumbering all the old slides and index cards—a formidable task—but one which we feel worthwhile in view of the interesting and valuable records which might otherwise be lost.

Another necessity has been to make a procedure book, with special attention to the disease index and the use of standard nomenclature. In this way, we hope that there will be the least possible confusion over the use of this system and, therefore, the greatest possible amount of use—for of what value are clinical photographs if they are not used



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Civil Defence Study

(Concluded from page 42)

plan into community planning, led by Dr. G. E. Fryer and Dr. J. W. Tice, Hamilton. Dr. R. G. Struthers, representing the provincial civil defence organization, outlined how civil defence operates on a regional basis and Colonel Shier, Central Command, Oakville, outlined the role of the Army. At the final session, Miss E. A. Pepper (assisted by S. W. Martin, associate executive secretary of the Ontario Hospital Association, and Dr. Piercey) led a discussion on keeping the plan functioning. All meetings were held in the nurses' residence of the Hamilton General Hospital.

The excellent local arrangements made for the delegates by the Hamilton General Hospital included a dinner at the Nora Frances Henderson Hospital and a conducted tour of this beautiful new institution.—*Dr. W. D. Piercey.*

Minister Reviews Health Scene

(Concluded from page 44)

they can be thought of merely as construction problems.

A good hospital means also an efficient staff, modern equipment, intelligent and experienced management. To be truly successful, a hospital must carefully match its work with the particular needs of the community it serves and the general hospital pattern of its area. By recognizing this principle Canada's hospitals have established high standards of excellence—in education, in research, and above all, in patient care. In our hospitals we have intelligent direction and integrity and the inspiration that comes from giving devoted and humanitarian service.

Across the entire field of health, new developments are taking place. Preventive medicine is receiving increased emphasis. Public health facilities are being strengthened in both urban and rural areas. More is being done to guard the health of our school children. Better services for mothers and children are being developed under the child and maternal health grant. A recent change in the hospital construction grant makes federal aid available for the development of training facilities in hospitals. In every area of health activity new hope is being

brought to individual citizens in every province.

The success of Canada's National Health Program has been made possible by the very close co-operation of federal and provincial health authorities, hospital and other health workers and voluntary health agencies across the country. It has been built on the foundations that the members of the health professions have so firmly laid. The support and encouragement which we have received from hospital administrators and trustees and from all who have a personal interest in our hospitals must continue if we are to work out in common purpose the best ways in which to take effective action against disease and ill-health.

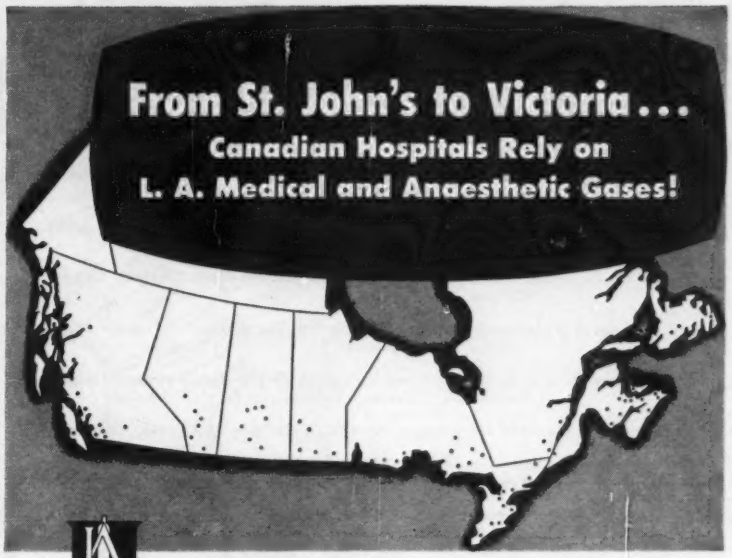
Ontario Receives Increased Civil Defence Grant

The federal government has agreed to increase its contribution to the cost of standardizing fire hose couplings in Ontario. The undertaking is an extension of an agreement under which the national government contributed one-third of the then-estimated cost of hose standardization in Ontario. Similar contributions have been made to other provinces.

Originally Ontario had estimated that it would cost $900,000 to adapt hose couplings throughout the province so that they would be interchangeable and that all Ontario fire-fighting equipment could be employed anywhere in time of need. On the basis of that estimate, Ottawa made a civil defence grant of $300,000 to Ontario.

Now, it has been found that considerably more equipment than was first believed requires standardization, particularly in large industries. Apparently early estimates were based on incomplete inventories of hose coupling requirements in many establishments. Ontario government and industrial authorities have advised the federal government that complete hose coupling standardization will cost a total of $1,100,000. The federal government will raise its contribution to Ontario to $367,000. Two other provinces, British Columbia and Alberta, have arrangements similar to those made with Ontario; and a similar offer is available to all the provinces.

Doing good to others is not a duty. It is a joy, for it increases your own health and happiness.—*Zoroaster*



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Coming Conventions

Feb. 16-18—Accounting Institute, sponsored by the Ontario Hospital Association, King Edward Hotel, Toronto, Ont.

May 2-6—National League for Nursing Convention, Kiel Auditorium, St. Louis, Missouri

May 9-11—Canadian Hospital Association Biennial Meeting, Chateau Laurier, Ottawa.

May 30-June 3—Maritime Hospital Association Convention, Prince of Wales College, Charlottetown, P.E.I.

May 30-June 3—Ninth International Congress of the International Hospital Federation, Lucerne, Switzerland.

June 10-11—Associated Hospitals of Alberta, University of Alberta, Edmonton.

June 13-18—Western Canada Institute for Hospital Administrators and Trustees, University of Alberta, Edmonton.

June 20-24—Conjoint meeting of the British Medical Association, the Canadian Medical Association, and the Ontario Medical Association, Royal York Hotel, Toronto, Ont.

June 27-29—Canadian Dietetic Association Convention, Royal York Hotel, Toronto, Ont.

June 27-29—Annual Meeting of the Comité des Hôpitaux du Québec, St. Laurent College, Montreal, P.Q.

Sept. 19-22—American Hospital Association Convention, Atlantic City, Convention Hall, Atlantic City, N.J.

Oct. 11-14—British Columbia Hospital Association, Vancouver.

Oct. 24-26—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Love of Beauty

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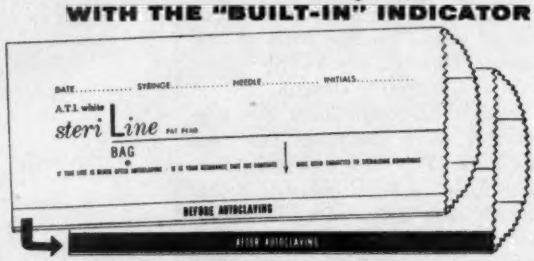

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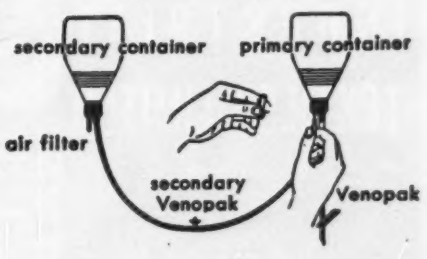

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This program was started on a federal basis when a civilian rehabilitation branch was established in the federal Department of Labour in 1952. The national co-ordinator, Ian Campbell, was appointed to work closely with the division of vocational training, the National Employment Service, and the departments of National Health and Welfare, and Veterans' Affairs to ensure complete integration of governmental services and finances in the rehabilitation process. It is his responsibility, furthermore, in co-operation with the national advisory committee on the rehabilitation of disabled persons, provincial governments, and voluntary agencies . . . to work towards bringing necessary treatment and services to . . . the "grass roots" in every community.—*H. C. Hudson, assistant co-ordinator of civilian rehabilitation, Department of Labour, Ottawa.*

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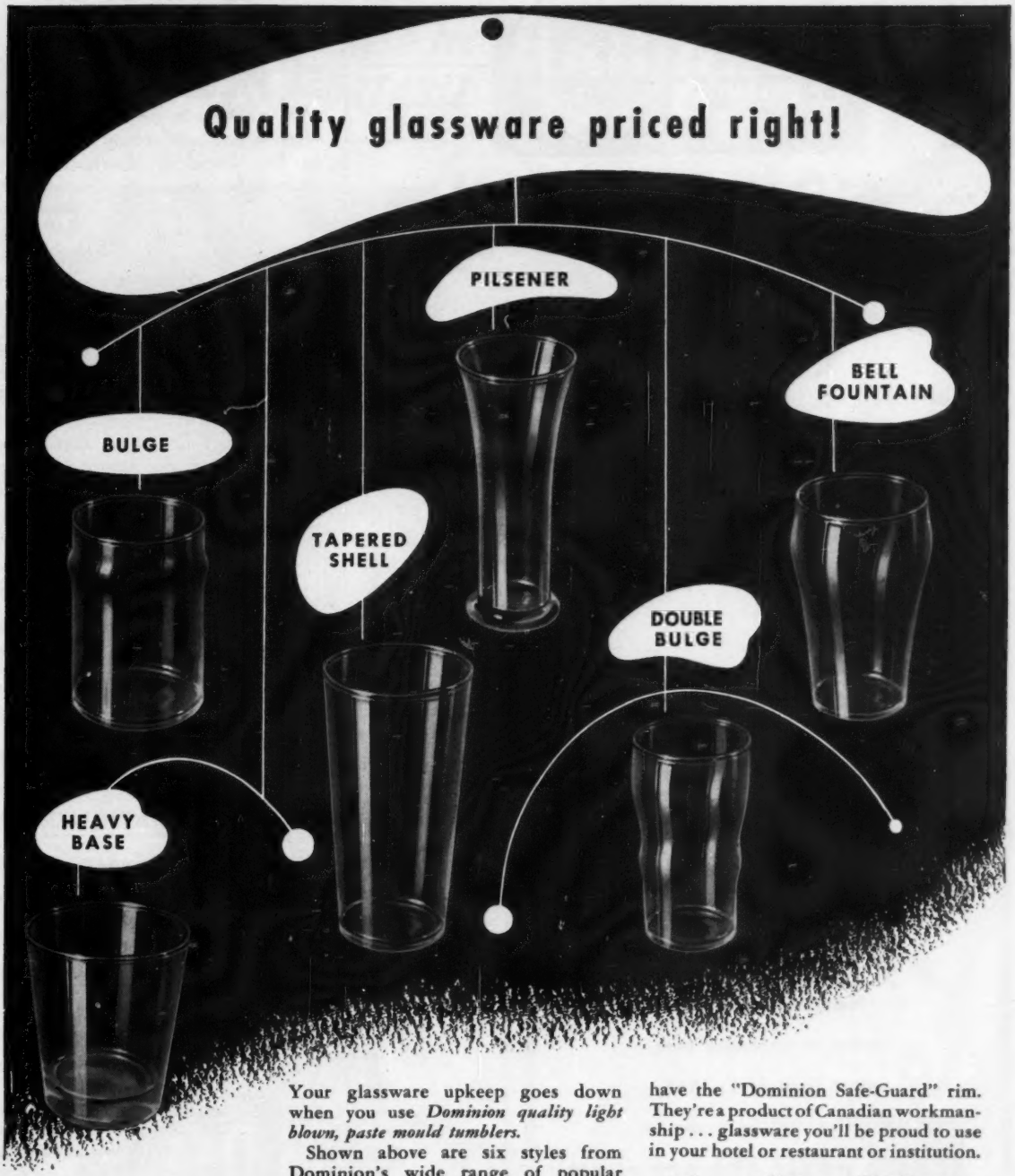

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Study of Chronic Acne Vulgaris

A group of patients with chronic acne vulgaris showed "dramatic improvement shortly after the administration of vitamin C and citrus juices without change in the previous method of treatment", according to a report by Dr. George E. Morris, assistant clinical professor of dermatology, Tufts College Medical School, in *Archives of Dermatology and Syphilology*. September, 1954. Dr. Morris described a four-month study involving 53 patients with acne vulgaris, all of whom were given an eight-ounce glass of citrus juice twice daily and ascorbic acid in a dose of three grams a day. Forty-three of the 53 patients showed improvement. Dr. Morris stated that "This study seems to substantiate the findings of the British Medical Research Council in that Vitamin C and citrus juices play an important part in certain cases of acne".

You give but little when you give of your possessions. It is when you give of yourself that you truly give.—*Kahlil Gibran.*

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With the Auxiliaries

(Continued from page 58)

first year, 212 volunteers have contributed 10,000 hours of work, serving 20 departments of the hospital.

* * * *

Auxiliary at Listowel, Ont., Helps Refurnish Maternity Ward

The maternity ward at the Listowel Memorial Hospital, Listowel, Ont., will be completely refurnished, at an approximate cost of $1,600, and the women's auxiliary to the hospital has agreed to pay half the cost. The hospital's board of trustees will share the cost with the auxiliary. The auxiliary has also agreed to pay $225 to cover the purchase of a new wall stand for the operating room.

* * * *

Auxiliary Aids New Hospital

At the annual meeting of the ladies' auxiliary to the new Northwestern General Hospital, Toronto, Ont., the treasurer reported that $10,195 had been raised during the past year. The money was used to purchase linens, uniforms, nursery supplies, and other items, which were presented to the hospital when it opened last year.

* * * *

Pantry Drive Successful

Over 1,000 jars of fruit, jams, jellies, and pickles were collected by the women's auxiliary to St. Marys Memorial Hospital, St. Marys, Ont., during a recent pantry drive. The treasurer's report showed a bank balance of $1,194.27, and members moved to send $250 to the hospital for the purchase of linens. At the beginning of the new year, the first baby born in the hospital received a spoon and, at Christmas time, the auxiliary provided Christmas trays for the patients.

* * * *

Auxiliary Donates Isolete

The women's auxiliary to the Guelph General Hospital, Guelph, Ont., recently donated an isolete, valued at $865, to the hospital. Money to purchase this equipment was raised at a strawberry festival and hospital tag day. During the past year, the auxiliary also donated an oxygen analyser, several beds for children, and a number of bedside tables. Some 83,000 bandages were packaged by the women.

* * * *

New Auxiliary Active

Over $2,000 was raised by the women's auxiliary to the South Huron Hospital, Exeter, Ont., during the past year. The hospital has only been open since 1953 and the ladies have provided bedding, towelling, and other supplies during that time.

Studying Hospital Construction

A new hospital building centre, the National Centre for Hospital Building and Technique, has been set up in Italy, under the auspices of the Italian National Association of Engineers and Architects. Its objects are to further the study of technical problems connected with hospital construction; to place its facilities at the disposal of all those interested in this field; to stimulate and maintain contact, both nationally and internationally, between Italian and foreign hospital architects and technicians; to facilitate the dissemination of information on hospital construction by means of the national and foreign press.— *"News Bulletin", International Hospital Federation, Sept., 1954.*

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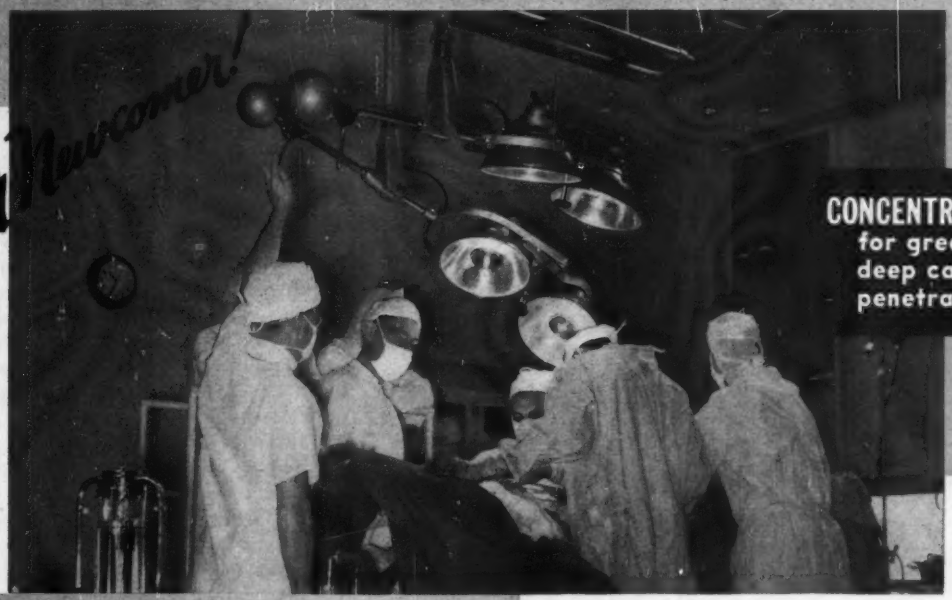

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Patients and Books

(Concluded from page 39)

are separated but we do work together. At times the occupational therapists will bring the patients to the library for their books. Sometimes they come in and ask us for books for certain patients, which they deliver, especially if they know we will not be on that ward for a few days. Other times the therapist will tell us about a patient and will ask us to call on him with the truck. The nursing staff aids us tremendously. When a patient is discharged they keep any library books he had until our next visit. Occasionally a nurse will telephone and relay a message from a patient desiring books. At Sunnybrook the staff use the library as a branch of the Toronto Public Library, under library rules. The patients, however, are not limited either to the number of books they may borrow at a time or the length of time they may keep them.

The modern library is not just a place for books and magazines. At Sunnybrook, for the past three years, we have had in the winter a handicraft display of the work of the staff and the patients. This has been quite successful and the occupational therapy and arts and crafts departments have co-operated in collecting the work, judging it, and setting it up. The canteen funds have provided money for prizes. This naturally has given added incentive to the project. In connection with the show we put out a great variety of books covering the various hobbies and crafts.

Occasionally we get letters from patients after they have been discharged. One older man, who at the time was quite difficult to satisfy, wrote, "Would like to thank you for all you done for me, you sure saw to it I had all the reading I needed and the type I liked. It paid off, made fifty bucks on an article I wrote subject A Flag for Canada". Another patient wrote, "The staff there are most helpful to the patients and the library improves and comforts the mind while the medical staff heal the body". Appreciation, naturally enough, cheers us immensely and we work all the harder at our task. Recently we were very pleased when a young patient, who was being discharged after psychiatric treatment, came in to say good-bye. He told us that we had been of great assistance to him and that the books we had given him had helped him to settle down and stop worrying over his troubles.

Not infrequently I have been asked whether I find hospital library work depressing. Definitely, I have not found it so. In a hospital such as Sunnybrook, where the patients are usually in hospital for some time, we have a chance to get to know our patients fairly well. Any librarian in a hospital has a close contact with her public. In fact, I find it most enjoyable and feel that I am doing a worthwhile task when I manage to convince a person that books are interesting and useful and that reading can be a pleasure. It leaves one with a sense of accomplishment and satisfaction.

In conclusion, I would like to quote from an article by Margaret M. Kinney in the *Special Libraries* publication for July-August, 1946, which I think sums up very well the purpose and value of libraries in hospitals. "Bibliotherapy as practised by most librarians in hospitals may be considered nothing more

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than good library service which strives to take into consideration the individual differences of the patients, including the factor which has resulted in their hospitalization. Such library service whether or not it extends into the field of bibliotherapy, as such, makes a recognized contribution towards the well-being of the individual. It should not be forgotten that the influence of reading as recreation and amusement to bolster morale and as a social aid to all kinds of patients is also a part of bibliotherapy."

Surgical Research at Strasbourg

Pure and disinterested research today requires vast laboratories conceived on an entirely new level and possessing the most up-to-date technical instruments. All these have been provided at the Surgical Research Centre at Strasbourg which may well become again the European centre for experimental surgery, as it was between 1930 and 1936. The elegant building which houses the laboratories rises in the magnificent park of the Strasbourg almshouses and is quite near the surgical clinics. Two complete research departments have been established and each contains (a) a division for experimental surgery with kennels for animals under observation; and (b) a series of laboratories designed for studying the physical chemical and hormone reactions of the patient before operation, so as to ensure that he suffers the minimum amount of "shock" from the intervention. During the past year more than 150 surgeons from other countries have gone to Strasbourg, some as visiting lecturers, to observe the work in progress there and to explore the surgery of tomorrow.—*René Delange, courtesy, Service D'Information Francais, Ottawa.*

Proper Study of Mankind

Any approach to illness which does not consider psychological and social data is not only likely to be one-sided and often unrewarding but is also in a sense reducing the practice of medicine from a professional to a technical level.

I think it is worth re-emphasizing that man is the proper study of mankind, even in his illnesses, and that the study of man is incomplete without a knoweldge of the inner and outer forces which determine his relation to himself and to his fellow men.—*Dr. Jules V. Coleman.*

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Friends of British Hospitals

The past year or two have seen an increase in the number of charitable organizations attached to Britain's National Health Service Hospitals. The organizations are usually known as the League of Friends of the particular hospital with which they are connected.

There are several hundred of these leagues up and down the country, most of them affiliated to a National League which has its headquarters in London.

Before the Health Service was created many voluntary hospitals had been adopted by local organizations, which supplied amenities for patients and staff. They helped to buy equipment and provisions and pay for the cost of building new departments.

With the advent of the Health Service, on the assumption that the Government was taking over all their responsibilities, nearly all these organizations were either disbanded or found some other object for their activities. When after a few years it became evident that certain facilities were lacking in several State hospitals, these organizations were reborn. At first some hospital administrators viewed their work with suspicion and openly discouraged them. Eventually, however, many hospitals came to rely upon them for the provision of certain patients' comforts.

Recently one group of hospitals conducted an inquiry into suggestions made by patients. The committee in charge of the inquiry referred many suggestions about the lack of certain amenities to the League of Friends.

Official approval was accorded the leagues when the Minister of Health (the Rt. Hon. Iain Macleod, M.P.) spoke at the recent annual conference of their national league. He strongly advocated the creation of a league of friends for every hospital in the country. Mrs. Macleod, it is interesting to note, is an active member of her local league.

The items provided by these leagues are usually concerned directly with patients' welfare, and include items such as television sets, bedside radios, armchairs and even luxuries like electric shavers. A few donate equipment to make nurses' duties less arduous, with the end in view that nurses will then have more time to devote to paients. One league, however, is planning to equip and furnish entirely a new outpatient department.

The most unusual and novel item yet provided by one of these leagues was recently presented to Worthing Hospital (Sussex) by its League of Friends. It is an induction wireless system, consisting of radio headphones which do not have to be plugged in to a point and, therefore, have no trailing wires attached. An insulated wire from a radio amplifier is tacked round the walls of the wards and sets up a magnetic field to which the headphones—known as "stethophones"—are receptive. The headphones resemble a doctor's stethoscope

—hence the name—and contain neither valves nor batteries. The system was invented by a London radio engineer, Victor Foot. A variation of the idea is a "call doctor" system shortly to be installed in a London teaching hospital. The receiver in this case is a small box-shaped object which clips into the doctor's top pocket. It will summon doctors in any part of the hospital and in the immediate vicinity.—*A. Whiteman, London, Eng.*

Novel Idea for Floor Cleaning

An interesting feature of the new out-patient department, recently completed at the Hospital for Sick Children, Great Ormond Street, London, Eng., is the floor cleaning equipment which has been installed throughout. The floors are sprayed from hoses which can be attached to the pressure nozzles fitted at skirting-board level at intervals round the walls; the floors have been fitted with gullies which drain off most of the water directed onto the floors while the excess water can be mopped up by "squeegees". By this method it is hoped that at the end of the daily session, a small trained staff, known as "floor hygienists", wearing rubber boots and equipped with the "squeegees" will be able to complete the cleansing of the department very quickly. All the fittings have been specially made to enable this method of cleaning to be carried out with dispatch. The furniture is on cast aluminum legs so that the spraying of the floors will not cause corrosion or damage to the furniture, while bench and cupboard units are purposely made so as to give an uninterrupted floor surface.

Any dampness which remains after this method of cleaning can be removed by the system of embedded floor panels which partly heat the building. The heating and cooling of the building, to compensate for rapid changes in the external atmosphere, can be accomplished by controls on the mechanical ventilating system. Softened water is provided to all sanitary fittings.—*"The Hospital, September, 1954.*

We are marching along the endless pathway of unrealized possibilities of human growth.—*Francis W. Parker*

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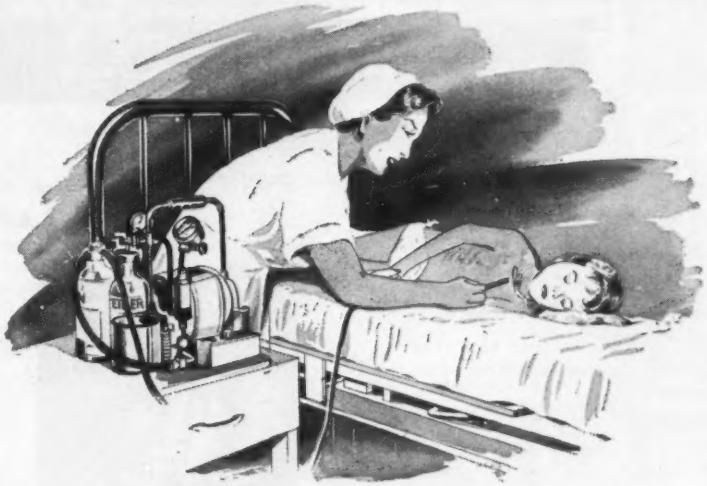

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This power must be immediately available, it must be dependable, and it must have sufficient capacity to handle **all** essential lighting and electrically operated equipment.

Onan engine-driven emergency electric plants meet all these requirements. When storms, floods, fires or breakdowns interrupt the electric power supply, Onan Standby plants start automatically and feed electricity to critical points. The plants stop automatically when regular power is restored. Will run continuously if necessary.

Onan Emergency Electric Plants are available from 1,000 to 100,000 watts A.C. to meet the needs of any hospital.

MODEL 10 HQ
10,000 watts A.C.

ONAN STANDBY PLANTS

Available with exterior housing, like the one shown, or without. All come complete with necessary controls and instruments, ready for installation. Automatic line transfer controls are available for all units.

GASOLINE-POWERED MODELS

Air-cooled: 1,000 to 10,000 watts AC
Water-Cooled: 10,000 to 100,000 watts AC

Write for folder and FREE engineering assistance.

Onan PRODUCTS

D. W. ONAN & SONS INC.

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News Released by Hospital Supply Houses

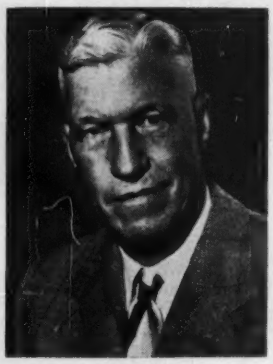
By C.A.E.

Executive Changes at Colgate-Palmolive

Mr. C. G. Grace was elected president of Colgate-Palmolive Limited effective January 1st, 1955, according to an announcement made by William L. Sims II, president of Colgate-Palmolive International Incorporated. The announcement coincides with the retirement of Mr. C. R. Vint, chief officer of the Canadian company, who will remain as a member of the board of directors.

Mr. Grace is a native of Albany, Missouri, and a graduate of Northwestern University. He was appointed executive vice-president and general manager of the Canadian company and elected to the board of directors on March 30, 1954.

Mr. Vint, the retiring president, has been associated with the Colgate-Palmolive Company for 51 years. A native of Sarnia, Ontario, he was chosen to establish the Canadian company in 1913 and has headed the organization ever since.



C. R. Vint

Smith & Nephew Appointment

Smith & Nephew Limited has announced the appointment of Allan R. Middleton as hospital representative in the Mid-West with headquarters in Winnipeg. Mr. Middleton has several years experience in the drug trade and he will service the Elastoplast, Gypsona and Nivea range of products in the Head-of-the-Lakes, Manitoba, and Eastern Saskatchewan territory.

C. G. Grace

Allan R. Middleton

New Canadian Surgical Supply House

The Medical Supply Association of Great Britain has established a Canadian subsidiary firm called Greville & Son Limited, with offices at 2719 Yonge Street, Toronto. Mr. J. L. Dalzell is manager and a director of the new firm. He has been with the parent Company for 28 years, first in Edinburgh and then in London.

The English Company has been active in the surgical equipment business since 1888 and has branches in many parts of the world. Their new 5,500-square-foot plant in north London is one of the largest of its kind.

J. L. Dalzell

Greville & Son Limited will handle many of the parent Company's lines including operating tables, instruments, rubber stores, needles and blades.

New Type Sterilizing Bag Introduced

A brand new development in needle and syringe sterilizing bags has just been announced. This new type bag, the A.T.I. "steriline" bag, has a "bulit-in" sterilization indicator that changes colour from white to black only under proper sterilizing conditions of time, steam and temperature. This new feature gives nurses and other hospital personnel the convenience of a bag plus the added assurance that its contents are sterile. Also, this new "sterline indicator" eliminates all doubt and confusion in the sterilizing room, in storage and at the instant of

(Concluded on page 98)

Planning a NEW LABORATORY?

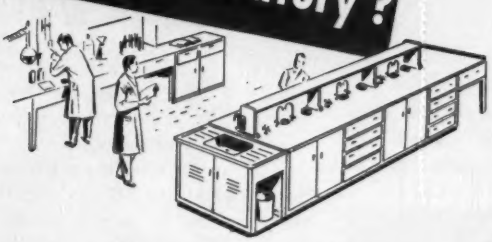
Let our representative sit in with you at your *earliest* planning session.

Early consultation with an experienced laboratory expert regarding layout, equipment, connections, lighting and entry pay off well in satisfaction and economy.

A smooth-working and effective layout can be assured and costly future alterations avoided.

There is no cost or obligation in using this service.

ADDING to your present laboratory?



Art Woodwork Limited and B. K. Johl Inc. are manufacturers and suppliers of a wide range of laboratory furniture — in wood or metal — including fume hoods, cabinets, counters, tables and service islands plus all the necessary fittings, fixtures and hardware.

A catalogue will be mailed on request.

ART WOODWORK LIMITED *Furniture in* **WOOD**

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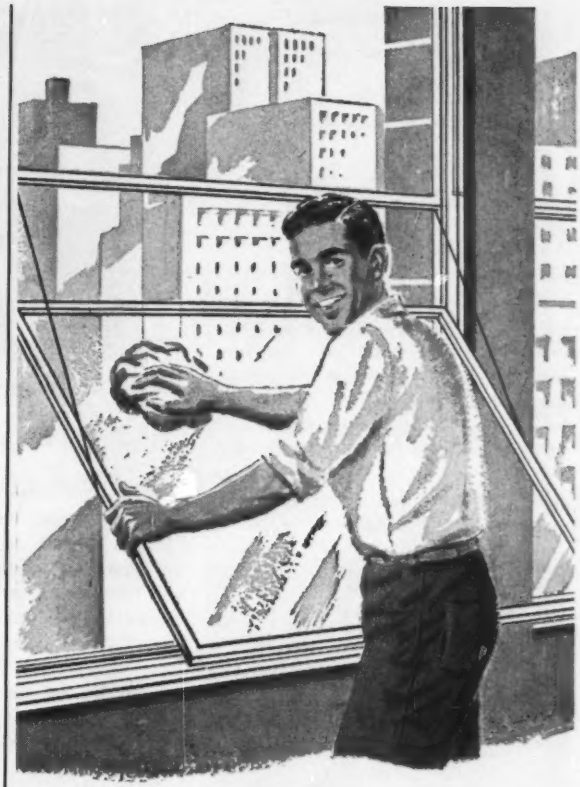

wash windows from inside with

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WINDOWS

CLERK Double Hung Aluminum Windows are made with reversible sashes that tilt inward at sill level to allow for safe, easy and frequent cleaning. All exterior glass can be washed from inside the building. Fly screens need not be removed. Window cleaners' bolts are not required.

CLERK WINDOWS are designed for the Canadian climate. Deep wool pile weatherstripping seals them against air infiltration. They may be fitted with single glass or removable double glazing.

CLERK REVERSIBLE WINDOWS are custom built of strong port-hole aluminum sections. They will retain their distinctive appearance and smooth operation for the life of the building.

To increase the operating efficiency of your next building, specify **"CLERK REVERSIBLE ALUMINUM WINDOWS".** For further information write:

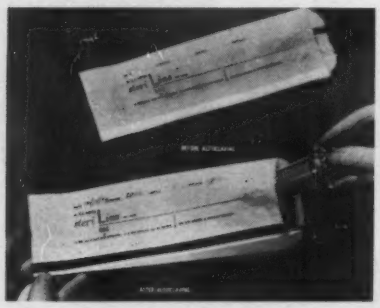
CLERK WINDOWS LIMITED
1499 Bishop Street, Montreal 25, Que.

Across the Desk

(Concluded from page 96)

use, as to which needles and syringes have been autoclaved, and which have not.

This new "steriline" bag with the "built-in" indicator, on which patent application has been made by the Aseptic-Thermo Indicator Company, has been under close laboratory study for more than a year and has been tested in actual use in 21 major hospitals. It is stated that the "built-in" indicator is a dependable method for determining if the contents and the bag have been subjected to sterilizing conlitions. This new feature, plus the fact that the bag is a time and labour saver, is a big advancement in hospital sterilization techniques.

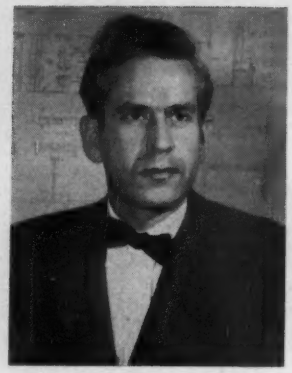


For free samples of these steriline bags, write directly to: Aseptic-Thermo Indicator Company, 11471 Vanowen Street, North Hollywood, California.

Arthur Peckham Becomes Partner In Consulting Firm

Dr. Harvey Agnew, hospital consultant, has announced that, on January 1st, a re-organization became effective in the hospital consulting firm of Neergaard, Agnew, Craig and Westermann of Toronto. Arthur Peckham, Jr. R.A. of New York City, who has been a member of the firm for a number of years, is now a partner in the organization and will reside in Toronto.

The firm will now be known as Agnew, Craig and Peckham. New and larger offices have been set up at 200 St. Clair Avenue West at Avenue Road, Toronto. A close association will be maintained as hitherto with their New York associates, Neergaard, Agnew, Craig and Peckham. Mr. Helge Westermann, A.I.A., has withdrawn from the partnership to practise architecture in New York City but



Arthur Peckham, Jr.

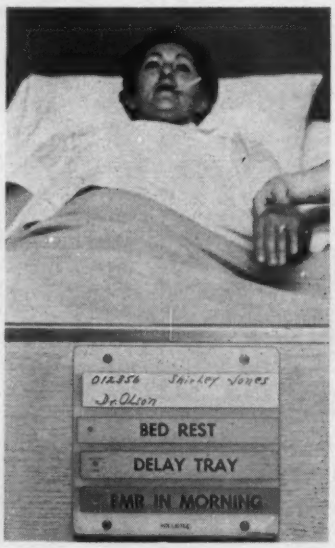
will maintain a close relationship with the firm.

Mr. Peckham has become well known in many hospital communities across Canada in recent years. A graduate in mechanical engineering and commercial art from New London Junior College, Mr. Peckham received his degree in architecture from the Yale School of Architecture. Since graduation, he has devoted practically all of his time to the study of hospitals and for most of this period has been a member of this firm.

As in the past, the services of this organization will be limited to consultation work in the designing of hospitals, to the study of their organization and management, and to conducting surveys.

Hollister Co. Introduces Bed Sign

Franklin C. Hollister Co., Chicago, have developed a new, modern plexiglas bed sign for hospitals. Each bed



sign is slotted to hold instruction cards, and is permanently attached to any style bed. Administrators and nurses who have test-used this product state that it meets a real need. The bed sign concentrates the instructions at one place—right with the patient. Plexiglas warning signs may also be attached to room doors.

The New Hollister bed signs build good will with patients and visitors by reflecting the individual care given to each patient. This is especially important in these times of understaffed and overcrowded hospital conditions. For more detailed information write to: Franklin C. Hollister Company, 833 North Orleans Street, Chicago 10, Illinois.

Kraft Foods Expanding

A new high mark for sales was established by Kraft Foods Limited in 1954, it has been announced by H. J. Henderson, president and general manager. But prospects for business in 1955 are even better.

Kraft's post-World War II program of constructing modern sales and distribution branches throughout the Dominion is virtually complete. It will reach its culmination in the new plant on Côte de Liesse Road in the town of Mount Royal, a portion of which will be devoted to Montreal sales branch, supplying much of eastern Ontario and most of the province of Quebec. Rapidly expanding business may call for additions at several of the big sales and distribution branches within the near future.

Each step, however, is designed for better service to its clientele, nearly all of which by now is within easy reach of modern sales branches. As conditions make it necessary, such expansion will develop.

Packaging many items especially for the hospital, hotel, restaurant and institutional trade, Kraft is making good progress in serving the establishments in this field.

Abbott Appointments

At a sales meeting held at Ste. Adele-en-haunt, Quebec, in December, appointments of Gerard R. Tremblay as Canadian divisional sales manager, and of Armand Grenier as Quebec and Maritime districts sales manager were announced by H. S. Wilkinson, vice-president and sales director of Abbott Laboratories Limited, Montreal.

Replace Worn-Out

NETS and PADDING

It pays in *EFFICIENCY*

Whatever Your Needs — Stanley Brock Ltd. can supply you. We have complete stocks of both, priced right, and on hand for Immediate Delivery: For information about:

- **Cotton Nets**
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Specializing in Equipment and Supplies for the Hospital Laundry for over 50 years.

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DISPOSABLE NIPPLE COVERS . . .

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2"-3"-4"-5"-6"-8"

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Enquire about special discounts on quantity lots to hospitals.

Price of $15.50 includes sales tax and shipping charges prepaid to any address in Canada, conditional upon Postal, Bank or Express Money Orders accompanying your Order.

Navy Blue Frieze

Best quality navy blue frieze with military scarlet flannel lining. Price $15.50.

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Measures standard 38" from seam of collar to bottom of hem. Stocked in even bust sizes from 32 to 42.

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Handworked Gold Silk letters supplied at 15c per letter. Please specify exact lettering and position when ordering.

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have CLEAN paper towels always handy!

So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

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